

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 28 Laing Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Howard T. Athey

3. (b) Social Security Number

219-03-9604

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widower6. (b) Name of husband or wife Josephine Korn

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Oct. 5, 1879

8. AGE:

Years

Months

Days

If less than one day

681010

hrs.

min.

9. Birthplace Keyser, W. Va.

(Town, county, and state)

10. Usual occupation retired shop foreman11. Industry or business Railroad

FATHER

12. Name Thomas Athey13. Birthplace Moorefield, W. Va.

MOTHER

14. Maiden name Carrie Mytinger15. Birthplace Romney, W. Va.16. Informant Mrs. Myrtle HanzellAddress 911 Brentwood St.17. Cremation
(Burial, cremation, or removal, Which?)Date thereof August 19, 1948
(month) (day) (year)Cemetery or crematory Cedar HillLocation Washington, D.C.18. Funeral director John J. HefnerAddress Cumberland, Md.19. Aug 18 1948
(Date rec'd by registrar)Walter A. Frank, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1948 at 11:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19 and that I last saw him Dead Aug. 16 1948

Immediate cause of death

Hemothorax, due to a crushed
chest, left side, 2nd, 3th, 4th, &
5th ribs fractured.

DURATION

3Due to being hit by a passenger
train engine at Baltimore St.
crossing 8-12-18-9-36-P.M.

Due to

Other conditions Fracture of pelvis &
abrasions, left side of face, hand
& knee (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results yes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-12-48Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) as aboveMeans of injury Hit by an engine Injured at work? noDeputy Medical Examiner - Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland Md. Date signed 8-16-48

RECEIVED

AUG 24 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

1. PLACE OF DEATH:

County... ALLEGANY
CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 City or town...
 How long in above place of death? 8 DAYS 75 years
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY
 City or town... CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
630 ELM ST CITY
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

MR BERNARD BEYOLKEY

3. (b) Social Security Number

705-12-2269

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED
 6.(b) Name of husband or wife ANNA ~~KIEFNER~~ Kieffner
 7. Birth date of deceased (mo., day, yr.) October 8, 1872 6.(c) If alive, give age 68 years
 8. AGE: Years 75 Months 10 Days 8 If less than one day
 9. Birthplace GERMANY (Town, county, and state)
 10. Usual occupation RETIRED (B & O)
 11. Industry or business

12. Name BEYOLKEY JACOB
 13. Birthplace GERMANY
 14. Maiden name ~~KIEFNER~~ ANNA Mary?
 15. Birthplace GERMANY

16. Informant MEMORIAL HOSPITAL
 Address MEMORIAL AVE CITY
 17. Burial Date thereof August 19, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Mary's Cemetery
 Location Cumberland, Md.

18. Funeral director John J. Roper
 Address Cumberland, Md.

19. Aug 18 19 48 Walter R. Roper
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 16 19 48 at 2:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-31-47 to Aug. 16, 1948and that I last saw him alive on Aug. 16, 1948

Immediate cause of death

Reverberal ArterioSclerosis (marked)GeneralizedArteriosclerosisDiabetes Mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.F. Williams M. D. Aug 17-48Address Cumberland Date signed 8-17-48

RECEIVED

AUG 24 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07902

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

In his automobile, Fredrick St. near
George St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County GarrettCity or town Grantsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lawrence G. Bittinger

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Elizabeth O. Bittinger6. (c) If alive, give age 57 years7. Birth date of deceased (mo., day, yr.) Nov. 1- 18868. AGE: Years Months Days If less than one day
61 hrs. min.9. Birthplace Grantsville Md.
(Town, county, and state)10. Usual occupation Retired, rural mail carrier

11. Industry or business

12. Name Thomas H. Bittinger13. Birthplace Grantsville Md.14. Maiden name Elizabeth Hoover15. Birthplace Grantsville Md.16. Informant Wife) Elizabeth O. BittingerAddress Grantsville Md.17. Burial Date thereof Aug 29 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GrantsvilleLocation Grantsville Md. yard18. Funeral director Wm. A. WinterbergAddress Grantsville Md.19. Aug 28 19 48 Winterberg
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 19 48 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him alive Dead Aug. 26 19 48

Immediate cause of death

Chronic myocarditis DURATION 2 yrs.

Due to _____

Due to _____

Other conditions Cardiac hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____
Deputy Medical Examiner Allegany Co.23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other _____Address Aug. 26-1948 Date signed 8-26-48

RECEIVED

AUG 31 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07903

Reg. Dist. No.

10

1. PLACE OF DEATH:

County..... AlleganyCity or town..... Slabtown, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 3 years

Hospital, institution, or street address where death occurred:

Highway, near home.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... AlleganyCity or town..... Slabtown
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)2.(a) If veteran, name war..... World war 2

3. (a) FULL NAME

Robert Leo Bridges

3. (b) Social Security Number

220-10-8533

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife..... Wauneta R. Lease Bridges

7. Birth date of

deceased (mo., day, yr.)

Oct. 27-1914

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

33921

hrs.

min.

9. Birthplace..... Elk Garden, W. Va.
(Town, county, and state)10. Usual occupation..... Steel Worker11. Industry or business..... Hazelwood Contracting Co.12. Name..... Edgar L. Bridges13. Birthplace..... Beans Cove Pa.14. Maiden name..... Grace Ream15. Birthplace..... Bedford Co. Pa.16. Informant..... Mrs. Leo Bridges

Address

Slabtown, Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof..... 8/21/48
(month) (day) (year)Cemetery or crematory..... Methodist CemeteryLocation..... Mt. Savage, Md.18. Funeral director..... Jacob HaferAddress..... 23 East Main Street, Frostburg, Md.19. 8-20 1948
(Date rec'd by registrar)Vernice M. Derman
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 18 19..... 48 12 40 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... in bed..... Aug. 18 19..... 48

Immediate cause of death.....

Intracranial hemorrhage

DURATION

at
onceDue to..... a self inflicted 25 caliberBelgium automatic pistol wound** through skull.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Suicide Date of..... 8-18-48Where did injury occur?..... Slabtown Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... near homeMeans of injury..... as above Injured at work?..... noDeputy Medical Examiner..... Allegany Co.23. SIGNATURE..... H. V. Deming M.D. H. V. Deming M.D.
M. D. or M. D. or M. D.Address..... Cumberland Md Md. Date signed..... 8-18-48

RECEIVED

AUG 23 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany
 City or town Slabtown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Years
 Hospital, institution, or street address where death occurred:
Highway, near home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Slabtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Wauneta R. Lease Bridges

3. (b) Social Security Number

212-24-1444

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white married6. (b) Name of husband or wife Robert Leo Bridges

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 31 - 19298. AGE: Years Months Days If less than one day
18 10 17 _____ hrs. _____ min.9. Birthplace Cresaptown, Md.
(Town, county, and state)10. Usual occupation Seamstress11. Industry or business Garment Factory12. Name Vance Cecil Lease13. Birthplace Cresaptown, Md.14. Maiden name Mary E. Shuck15. Birthplace Cresaptown, Md.16. Informant Mrs. Vance LeaseAddress Cresaptown, Md.17. Burial Date thereof 8/31/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Methodist CemeteryLocation Mt. Savage, Md.18. Funeral director Jacob HaferAddress 23 East Main St., Frostburg, Md.19. 8-20 19 48 Vernice M. Vermitt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 19 48, at 12.40 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him Dead Aug. 18 19 48Immediate cause of death Intracranial hemorrhage at
(Homicide) onceDue to being shot by her husband
in head by a 25 caliber Belgian
automatic pistol.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 8-18-48Where did injury occur? Slabtown Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) near homeMeans of injury as above Injured at work? noDeputy Medical Examiner - Allegany Co.23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress Cumberland Md. Date signed 8-18-48

RECEIVED

AUG 23 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

07905

1. PLACE OF DEATH:

County... Allegheny
 City or town... Frederick Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 yrs.
 Hospital, institution, or street address where death occurred:
7 S. Bernard St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Allegheny
 City or town... Frederick Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 7 S. Bernard St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Martha Lucinda Broderick

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 1st 1870 6. (c) If alive, give age _____ years

8. AGE: Years 78 Months 7 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Westernport Md.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Thomas Broderick

13. Birthplace Ireland

14. Maiden name Lavinia Carney

15. Birthplace Mt. Savage Md.

16. Informant Helena Colvin

Address 7 S. Bernard St.

17. Burial, cremation, or removal. Which? Burial Date thereof Aug. 14 1948
 (month) (day) (year)

Cemetery or crematory St. Peter's Cemetery

Location Westernport Md.

18. Funeral director Jacob Hailer

Address 23 E. Main St. Frederick Md.

19. 8-14 19 48 Ms. Nancy W. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 19 48 at 12:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13 19 48 to Aug. 13 19 48

and that I last saw her alive on Aug. 13 19 48

Immediate cause of death _____ DURATION _____

Chv. Myocarditis 1 year

Due to _____

Due to Severe Arteriosclerosis 12 yrs

Other conditions Deformities

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE WOM Lane MD M. D. or other _____

Address Frederick Md Date signed 8-14-48

RECEIVED

AUG. 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegheny

City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

326 Spruce St.

How long in hospital or institution? — — — — —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 Spruce St.

(If rural, give LOCATION)

2.(a) If veteran, name war U. S. # 1

3. (a) FULL NAME

EDWARD ARNOLD BRUMBACK

3. (b) Social Security Number

216-05-0724

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Grace Wilson

BRUMBACK. 6. (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 25, 1890

8. AGE: Years 58 Months 5 Days 19 If less than one day

9. Birthplace Liberty Furnace, Virginia
(Town, county, and state)

10. Usual occupation MACHINIST

11. Industry or business W. Va. Pulp & Paper Co.

12. Name AMOS BRUMBACK

13. Birthplace Virginia

14. Maiden name REBECCA MILLE

15. Birthplace West Virginia

16. Informant Mrs GRACE W. BRUMBACK

Address Westernport, Maryland.

17. Burial Date thereof Aug 17 1948
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Philas Cemetery

Location Westernport, Maryland

18. Funeral director Edwards S. Boal

Address Westernport, Maryland

19. Aug. 17 19 48 Registrar James W. Weston Jr MD

(Date signed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 48 at 5:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 47 to Aug 14 19 48

and that I last saw him alive on Aug 13 19 48

Immediate cause of death

DURATION

Due to Coronary Occlusion 5 minutes

Due to Coronary heart disease 1 1/2 years

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James W. Weston Jr MD

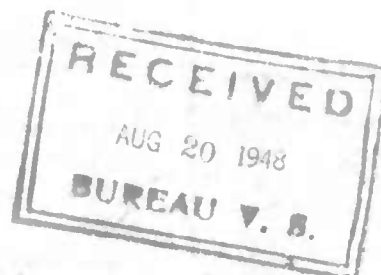
Address Piedmont W. Va. Date signed 8-16-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct a mistake by writing over it. If a mistake is made, write "corrected" and re-write the correct information. Physicians: please write the causes of death clearly and legibly. is especially important.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63B

07907

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
Miners Hospital
 How long in hospital or institution? 2 weeks 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 139 E. College Ave.
 (If rural, give LOCATION)
 2.(a) if veteran, name war ✓

3. (a) FULL NAME

Margaret ElizabethBUCKALEW

BUCKALEW

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife George R. Buckalew
 6.(c) If alive, give age 51 years
 7. Birth date of deceased (mo., day, yr.) Dec, 23, 1895
 8. AGE: Years 52 Months 8 Days 5 If less than one day
hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 19 48 at 100 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 48 to Aug 28 19 48
 and that I last saw him alive on August 28 19 48

Immediate cause of death Toxic adenoma Thyroid DURATION 4 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Large Toxic adenoma
of lobe of thyroid Date of op. 8/27/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Jansbury, M.D. M. D. or otherAddress Frostburg, Md Date signed 8/28/48

9. Birthplace Frostburg, Md
 (Town, county and state)
 10. Usual occupation Housewife
 11. Industry or business Own home
 12. Name John L. Beggie
 13. Birthplace Scotland
 14. Maiden name Sara E. Trout
 15. Birthplace Frostburg, Md
 16. Informant Mr. Geo. R. Buckalew
 Address Frostburg, Md
 17. Burial Date thereof Aug 31, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Allegany Cemetery
 Location Frostburg, Md
 18. Funeral director M. Eichhorn
 Address Lonsaving, Md
 19. 8-31 19 48 Wm. Nancy N. Roe
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. TOLSON

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH

3b, & correction of 6c, 13 & 16 2411 N. Charles St., Baltimore

shown on: **CERTIFICATE OF DEATH**

Reg. Dist. No. 07908

1. PLACE OF DEATH:

County **ALLEGANY**
City or town **CUMBERLAND**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **4 DAYS**
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? **4 DAYS**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **MARYLAND** County **GARRETT**
City or town **OAKLAND**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **OAK STREET**
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

JAMES W. BUTT

3. (b) Social Security Number

216-07-7069

4. Sex **MALE** 5. Color or race **WHITE** 6.(a) Single, married, widowed, or divorced **MARRIED**

6.(b) Name of husband or wife **ADDA McCURDY BUTT**

7. Birth date of deceased (mo., day, yr.) **AUGUST 6, 1877** 6.(c) If alive, give age **64 66** years

8. AGE: Years **71** Months **0** Days **7** If less than one day
.....hrs.min.

9. Birthplace **Shawnee, OHIO**
(Town, county, and state) **CLERK**

10. Usual occupation

11. Industry or business **STORE IN OAKLAND**

12. Name **SAMUEL BUTT**

13. Birthplace **WEST VIRGINIA Ohio**

14. Maiden name **RUTH KIMMY**

15. Birthplace **OHIO**

16. Informant **Adda McCurdy Butt**

Address **Oak St., Oakland Ind.**

17. **Burial** Date thereof **Aug 16, 1948**
(Burial, cremation, or removal. Which?) (month, day) (year)

Cemetery or crematory **Oakland Cemetery**

Location **Oakland Ind.**

18. Funeral director **Herbert Leigh**

Address **Oakland Ind.**

19. **Aug. 14 48** Registrar **C. R. Hunt, M.D.**

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **AUGUST 13, 1948** at **1:10 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **8-9-1948** to **8-13-1948**

and that I last saw him alive on **8-13-1948**

Immediate cause of death **Arteriosclerosis with Coronary sclerosis**

Due to

Due to

Other conditions **Benign hypertrophy prostate vesical vesical calculus**

(Include pregnancy within 8 months of death)

Major findings of operations **no operation**

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

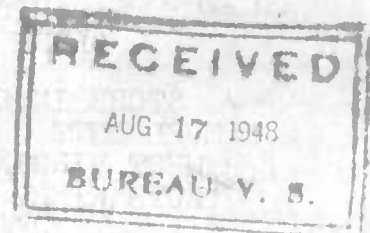
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Howard Tolson, M.D.**

Address **Cumberland, Md.** Date signed **8-14-48**



Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07905

170C

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred:
Memorial Hospital Cumberland Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. Va County Hampshire Co
City or town Greenspring W. Va
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name War _____

3. (a) FULL NAME

E. Sharon L. Cannon

3. (b) Social Security Number

234-40-3397

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1928 6. (c) If alive, give age _____ years

8. AGE: Years 19 Months 8 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Hampshire Co. W. Va
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Green Spring W. Va

12. Name Cecil P. Cannon

13. Birthplace W. Va

14. Maiden name Naomia O. Bunker

15. Birthplace Maryland

16. Informant Alvin Cannon (Brother)

Address Springfield W. Va

17. Burial Date thereof Aug 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Glen

Location Green Spring W. Va

18. Funeral director A. C. Ruckman

Address Romney W. Va

19. Aug 15, 48 W. R. Tarkenton, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 19 48 about 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I last saw him Dead Aug 15 19 48

Immediate cause of death Cerebral hemorrhage

Other conditions Fracture of pelvic bone

(Include pregnancy within 3 months of death)

Due to large hematoma of right thigh also

fracture of abdomen extending from

due to anteroposterior to mid-sagittal region

fracture of ilium

Other conditions Fracture of pelvic bone

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto accident Date of Aug 14, 48

Where did injury occur? Smiths R. & Romney Hampshire Co W. Va
(City or town) (County) (State)

Injured at home, farm, industry, pub'l place (where?) Highway

Means of injury Auto struck by train Injured at work? No

Deputy Medical Examiner - Allegheny Co

23. SIGNATURE H. V. Downing M.D. M. D. or other

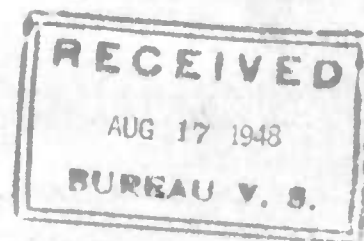
Address Cumberland Md Date signed Aug 15, 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07910

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County Mahoning
 City or town Youngstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2715 Mt. Vernon Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3.(a) FULL NAME

John T. Carney

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Helen Mc Elwee
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 11, 1885
 8. AGE: Years 63 Months 0 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Mt. Savage, Maryland
 (Town, county, and state)
 10. Usual occupation Machinist
 11. Industry or business Steel mills
 12. Name John Carney
 13. Birthplace Mt. Savage, Md.
 14. Maiden name Bridget Mulloney
 15. Birthplace Ireland

16. Informant Raymond W. Fannon
 Address Mt. Savage, Md.
 17. Burial Date thereof August 16, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Calvary Catholic Cemetery
 Location Youngstown, Ohio
 18. Funeral director John J. Hefner
 Address Cumberland, Md.
 19. Aug. 12, 1948 W.R. Tautz, M.D.
 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1948 at 9:35 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Aug. 1948 to 11 Aug. 1948
 and that I last saw him alive on 11 Aug. 1948

Immediate cause of death Cerebral Hemorrhage DURATION 1 week

Due to Hypertensive Vascular Disease ?

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

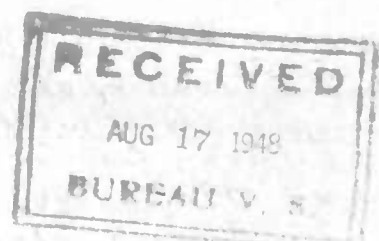
23. SIGNATURE W. Alfred Van Cleave

Address Cumberland, Md. Date signed Aug. 12, 1948
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07911

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50-8-27
Hospital, institution, or street address where death occurred:
551 N. Mechanic St.
How long in hospital or institution? D.O.A. at Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 551 N. Mechanic St.
(If rural, give LOCATION)

3. (a) FULL NAME

Reed Christopher Cassen

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Loretta A. Miller Cassen

7. Birth date of deceased (mo., day, yr.) Nov. 22- 1897 6. (c) If alive, give age 48 years

8. AGE: Years 50 Months 8 Days 27 It less than one day hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation City policeman

11. Industry or business

12. Name Jarriet W. Cassen

13. Birthplace Cumberland Md.

14. Maiden name Ellen Jane Hoenicka

15. Birthplace Cumberland Md.

16. Informant Mrs. Elizabeth McIntosh (sister)

Address 225 Bond St. Cumberland Md.

17. Burial Date thereof Aug 21 '48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Aug 20 19 48 Hunter & Prouty M.D.
(Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 19 48 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him in bed Aug 19 19 48

Immediate cause of death Coronary occlusion DURATION 1 1/2 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co

23. SIGNATURE H.V. Deming, M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 8-19-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07912 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport-Rural 2Mi. Rt 135
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Ohio
 City or town Wheeling
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 136-14th St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Genevieve M. Clark

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 9, 1893

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

55

hrs.

min.

8. Birthplace

Wheeling-Ohio- W.Va.

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

FATHER
MOTHER

12. Name

John B. Clark

13. Birthplace

Wheeling, W.Va.

14. Maiden name

Catherine Hussion

15. Birthplace

Ireland

16. Informant

Kathleen Howley

Address

Wheeling, W.Va.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

Aug. 2 48

(month) (day) (year)

Cemetery or crematory

Location

Wheeling, W.Va.

18. Funeral director

Ellsworth S. Boal

Address

Westernport, Md.

19.

Aug. 2 48

19

C. H. Hussion MD

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1 48 8P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him er Dead Aug 1 48

Immediate cause of death Intracranial Hemorrhage due to fracture of skull. DURATION 3 M.

Due to

Due to

Other conditions Fracture of cervical Vertebrae & several ribs fractured on left side of chest, also right patellae fracture

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLATION of death was due to external causes, in the following: Accident 8/1/48

Accident, suicide, or homicide

Where did injury occur? Near Westernport-Allegany-Md Date of

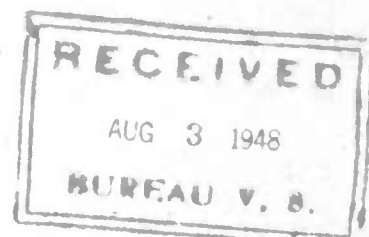
(City or town)

Rt. 135

(State)

Injured at home, farm, industry, public place (where?)

Means of injury Accidentally thrown from auto Injured at work?Deputy Medical Examiner Allegany Co.23. SIGNATURE H. V. Deming MD M. D. or otherAddress Cumberland Md Date signed 8-1/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 07913 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, institution, or street address where death occurred:
36 Mc Cullah St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 36 Mc Cullah St.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Paul Costello

3. (b) Social Security Number

217-10-5190

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife May Costello 6.(c) If alive, give age 6.6 years
7. Birth date of deceased (mo., day, yr.) Feb. 2nd 1885
8. AGE: Years 63 Months 6 Days 13 If less than one day hrs. min.
9. Birthplace Italy (Sicily)
(Town, county, and state)
10. Usual occupation Retired Calaveras worker
11. Industry or business
12. Name unknown
13. Birthplace
14. Maiden name unknown
15. Birthplace

16. Informant Mrs. May Costello
Address 36 Mc Cullah St. Frostburg
17. Burial Date thereof 8/15/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg, Md.
18. Funeral director Francis Raper
Address 238 Union St. Frostburg, Md.
19. 8-18 19 48 Mc Nalley & Co.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948 at 5:00 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1945 to Aug. 12, 1948
and that I last saw him alive on August 10, 1948
Immediate cause of death Pulmonary Tuberculosis DURATION 5 yrs.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

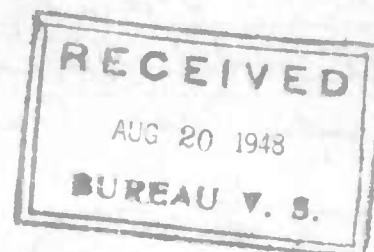
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE N. D. Gathers M.D.
M. D. or other
Address Frostburg, Md. Date signed 8/18/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Union Island
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred Allegheny Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rd. #5 Braddock Rd.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Violet Elizabeth Cromwell

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Eldred A. Cromwell
7. Birth date of deceased (mo., day, yr.) Dec 9, 1906
6. (c) If alive, give age years
8. AGE: Years 41 Months 7 Days 22 If less than one day hrs. min.

9. Birthplace Harrisburg, Penna.
(Town, county, and state)

10. Usual occupation Housewife
11. Industry or business at Home

12. Name Charles Hess

13. Birthplace Penna.

14. Maiden name Emel Scarfoss

15. Birthplace Penna.

16. Informant Eldred Cromwell

Address Rd #5 Cumberland

17. Burial Date thereof Aug 4 48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rural Still Em.

Location Cumberland

18. Funeral director Goni Stein Inc.

Address Cumberland

19. Aug. 4 19 48 W.P. Smith, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1st 19 48 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21st. 19 48 to August 1st. 19 48 and that I last saw her alive on July 31st. 19 48

Immediate cause of death cerebral hemorrhage DURATION 10 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

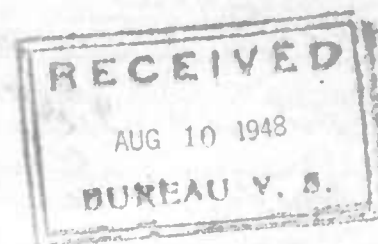
23. SIGNATURE [Signature] M. D. or other

Address 1158 Centinest Date signed 9-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

AUG 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

**Outside of
City Limits**

1. PLACE OF DEATH:

County Allegany
City or town R. D. #2 Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R. D. #2 Cumberland, Md.

How long in hospital or institution?

3. (a) FULL NAME

Hazel Liller Dowling

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1890

8. AGE: Years 58 Months 5 Days 0 if less than one day _____ hrs. _____ min.

9. Birthplace Moorefield, W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Liller
13. Birthplace W. Va.

14. Maiden name Sarah Bobo
15. Birthplace W. Va.

16. Informant Matthew Dowling
Address R. D. #2 Cumberland, Md.

17. Burial Aug. 30, 1948
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Philos Cem.
Location Westernport, Maryland

18. Funeral director H. Wayne George
Address Cumberland, Md.

19. Aug 30 19 48 Walter R. Smith, M.D.
(Date received by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town R. D. #2 Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Williams Road
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27, 19 48 at 12:29 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1, 19 48 to Aug. 27, 19 48
and that I last saw her alive on Aug. 26, 19 48

Immediate cause of death

Chronic Myocarditis

DURATION

6 wks

Due to

Coronary Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

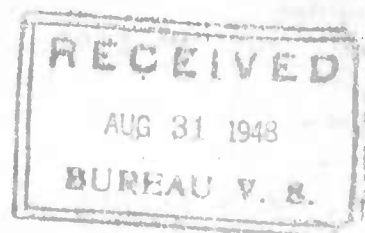
Means of injury

Injured at work?

23. SIGNATURE

Clayton L. Smith
Cumberland Aug. 28, 1948
Address _____ Date signed _____

M. D. or other



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07917

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
 City or town WESTERNPORT
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

GEORGE DUCKWORTH

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWER
 6. (b) Name of husband or wife JANET METZ
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) MARCH 3, 1884
 8. AGE: Year 64 Month 5 Day 27 If less than one day _____ hrs. _____ min.

9. Birthplace WEST VIRGINIA
 (Town, county, and state)
 10. Usual occupation ODD JOBS
 11. Industry or business _____
 12. Name OLIVER DUCKWORTH
 13. Birthplace MARYLAND
 14. Maiden name SCHMIDT, FLORENCE
 15. Birthplace WEST VIRGINIA

18. Informant From Hospital Records
 Address _____

17. Burial Date thereof Aug 29, 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Philas Cemetery
 Location Westernport, Md.

18. Funeral director Edmunds, St. Paul
 Address Westernport, Md.

19. Aug 29, 1948 Walter P. Bantz, M.D.
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 27, 1948 at 1:26 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 27, 1948 to Aug 27, 1948
 and that I last saw him alive on Aug 27, 1948
 Immediate cause of death Carcinoma of Lung
 (Indicate cause of death)

Due to _____
 Other conditions Metastasis
Carcinoma of Lung
 (Include pregnancy within 5 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Jacobson
 M. D. or other _____
 Address Westernport, Md. Date signed 8/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07918

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Near Cumberland Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Locust Grove, R. F. D. #6
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Allegheny
 City or town Near Cumberland Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Locust Grove, R. F. D. #6
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Nattie Dunn

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Feb. 29 1880
 8. AGE: Years 68 Months 5 Days 10 If less than one day hrs. min.

9. Birthplace md
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name George J. Dunn

13. Birthplace md

14. Maiden name Lelia Alderton

15. Birthplace md

16. Informant Miss Phoebe Ober

Address R. F. D. #6, Locust Grove Md

17. Burial Date thereof Aug 14 1948
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland Md

18. Funeral director Louis Stern Inc

Address Cumberland Md

19. Aug 10 1948 W. F. Frank M.D.
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1948 at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to Aug 9 1948 and that I last saw him alive on Aug 8 1948

Immediate cause of death Intral Staphylococcus
Septicemia Exanthema
 Due to Dermatitis Intral
with Bullae Sanguis
 Due to Malnutrition

DURATION

6 weeks

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

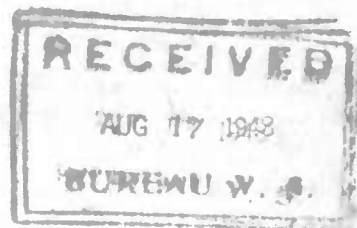
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Alan G. Murren M.D.

Address Cumberland Md Date signed Aug 9 1948

Dunn



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07919

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 Years
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? Six Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 318 Independence St
 (If rural, give LOCATION)
 2.(a) if veteran, name war

3. (a) FULL NAME

Joseph P. Faith

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Annie Faith
 7. Birth date of deceased (mo., day, yr.) July 14 1859
 6. (c) If alive, give age years
 8. AGE: Years 89 Months 1 Days 15 If less than one day hrs. min.

9. Birthplace Hancock, Washington Co., Maryland
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Laborer

12. Name John Faith

13. Birthplace Germany

14. Maiden name Mary (Unknown)

15. Birthplace Unknown

16. Informant Mrs. Ira King

Address 318 Independence St., Cumberland, Md.

17. Burial Date thereof 8/25/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter Cemetery

Location Hancock, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Aug 23 19 48 Walter D. Brady Registrar
 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22-48 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-18 19 47 to 8-22-48 and that I last saw him alive on 8-22-48

Immediate cause of death Uremia DURATION 3 weeks

Due to contracted

Due to kidneys DURATION 6 m

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mans of injury Injured at work?

23. SIGNATURE L. King M.D. or other Dr. J. J. J. Date signed 8-23-48

RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

07920

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

210 Grand Ave. Cumberland, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... W. Va. County..... MineralCity or town..... Keyser
(If outside city or town limits, write RURAL and give nearest town)Street No. 611 W. Piedmont St.
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Bertie Augusta Beall Gray

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife..... Winfield Scott Gray
3-16-477. Birth date of deceased (mo., day, yr.) Mar. 25, 18948. AGE: Years Months Days If less than one day
64 4 27 hrs. min.9. Birthplace..... Mineral Co., W. Va.
(Town, county, and state)10. Usual occupation..... Housewife

11. Industry or business

12. Name..... Joseph Beall13. Birthplace..... W. Va.14. Maiden name..... Joann Hartley15. Birthplace..... W. Va.16. Informant..... Joseph GrayAddress..... R#3, Keyser, W. Va.17. Burial Date thereof..... 8-25-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... QueenspointLocation..... Keyser, W. Va.18. Funeral director..... Rogers Funeral HomeAddress..... Keyser, W. Va.19. Aug 25, 1948 Walter R. Post, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 22, 1948 8:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1948 to Aug 22, 1948 and that I last saw him alive on Aug 22, 1948Immediate cause of death..... Barrenness of stomach
careemphatous

DURATION

1 yr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?

23. SIGNATURE..... Walter R. Post, Jr.Address..... Cumberland Date signed..... Aug 27, 1948

RECEIVED

AUG 31 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53

07921

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1008 Gay St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1008 Gay St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Samuel David Gray

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife Catherine C. Foreman

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1857 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
90 10 28 hrs. min.

9. Birthplace Frederick, Md.
(Town, county, and state)

10. Usual occupation Boatman - retired

11. Industry or business C & O Canal

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant John H. Gray

Address Cumberland Md.

17. Burial Date thereof Aug 6, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Ceme

Location Cumberland Md.

18. Funeral director **LOUIS STEIN, INC**

Address Cumberland Md.

19. Aug. 4, 1948 W. F. Trautz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1948 at 12:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947 to Aug 3 1948 and that I last saw h. — alive on July 25 1948

Immediate cause of death Epithelioma left neck DURATION 10 mo

Due to

Due to

Other conditions Melanosis cervical & mediastinal glands 6 mo.
(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Elbert Patterson M.D. M. D. or other

Address 122 So Centre Date signed 8-3-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Insert correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 10 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**Outside of
City Limits**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07922

95C

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Alligany
City or town Rural Route 2, Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Alligany
City or town (Rural) Rte 2 Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Mrs. Nellie Griffith

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widow
6. (b) Name of husband or wife Thomas Griffith
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) June 6-1882
8. AGE: Years 66 Months 2 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Frostburg Allegany Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Hartig

13. Birthplace Germany

14. Maiden name Mary Zisch

15. Birthplace Frostburg Md

16. Informant Carl Griffith

Address Route 2, Cumberland Md

17. Burial Date thereof Aug 24 1948
(Burial, cremation, or removal. Which?) (Month) (Day) (Year)

Cemetery or crematory Alligany Cemetery

Location Frostburg Md

18. Funeral director J. R. O'Quinn

Address Frostburg Md

19. August 24 1948 W. R. Kautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1948, at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw HER Dead Aug 22 1948

Immediate cause of death Coronary occlusion at once

Due to Coronary sclerosis

Other conditions Cardiac hypertrophy Several yrs

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

Deputy Medical Examiner - Allegany

23. SIGNATURE H. V. Arning M.D. M. D. or other

Address Cumberland Md Date signed 8-22-48

RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this certificate are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 66 days
 Hospital, institution, or street address where death occurred: Miners' Hospital
 How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... California County... Los Angeles
 City or town... Los Angeles
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5911 S. Wilton Pl
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas Henry Grose

3. (b) Social Security Number

320-10-7977

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mildred Grose
 7. Birth date of deceased (mo., day, yr.) July 2, 1900 6.(c) If alive, give age 45 years
 8. AGE: Years 48 Months 1 Days 13 If less than one day
hr.min.

9. Birthplace Frostburg Allegany, Md
 (Town, county, and state)
 10. Usual occupation electrician
 11. Industry or business Otis Elevator Co.
 12. Name James H. Grose
 13. Birthplace Maryland
 14. Maiden name Ollie Hager
 15. Birthplace Maryland

16. Informant Edgar Grose
 Address Frostburg Md.
 17. Burial Date there Aug 18, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Allegany Cemetery
 Location Frostburg, Md.
 18. Funeral director J. R. Hurst
 Address Frostburg Md.
 19. 8-18 19 48 Mr. Harry V. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 19 48 at 12:25A
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 19 48 to Aug 16 19 48
 and that I last saw him alive on Aug 13 19 48

Immediate cause of death Cerebral Embolism DURATION 25 hrs

Due to Coronary Heart Disease 8 mo

Due to.....
 Other conditions.....

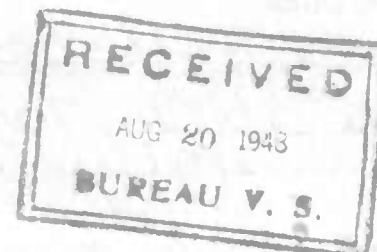
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE W. M. Lane MD M. D. or other
 Address Frostburg Md Date signed 8-16-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

07924

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? at once 2 hrs.
 Hospital, institution, or street address where death occurred:
Front 38 Baltimore St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 314 Pratt St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charles Edward Hartis Sr.

3. (b) Social Security Number

216-09-6431

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Clemma Greenhorn Hartis
 7. Birth date of deceased (mo., day, yr.) May 22 1885
 6. (c) If alive, give age 61 years
 8. AGE: Years 63 Months 2 Days 25 If less than one day hrs. min.

9. Birthplace Wilmington Del.
 (Town, county, and state)
 10. Usual occupation Supervisor at Lukes Paper Mill
 11. Industry or business

12. Name George Hartis
 13. Birthplace Del.
 14. Maiden name Elizabeth Cochran
 15. Birthplace Del.

16. Informant Chas. E. Hartis Jr.
 Address Luke Md.

17. Burial (Burial, cremation, or removal. Which?) Aug. 19 '48
 Date thereof (month) (day) (year)
 Cemetery or crematory Philos Cem.
 Location Westernport Md.

18. Funeral director Boal Funeral Home
 Address Westernport Md.

19. Aug 17 1948 Hunter & Prouty Md
 (Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 19 48 at 12.10 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive Dead Aug. 17 19 48

Immediate cause of death Coronary occlusion
 Due to coronary sclerosis
 Due to 3 yrs.

Other conditions Cardiac hypertrophy
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Manner of injury Injured at work?
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 Address Cumberland Md. Date signed 8-17-48

RECEIVED

AUG 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07925 9

1. PLACE OF DEATH

County Allegany
 City or town Frederick Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:
38 Linden St (home)
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Allegany
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 38 Linden St
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3. (a) FULL NAME

Marshall E. Hill

3. (b) Social Security Number

214-07-2523

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Lena Ella Lena Hill

7. Birth date of deceased (mo., day, yr.) March 18 - 1895 6.(c) If alive, give age 49 years

8. AGE: Years 53 Months 4 Days 27 If less than one day
 hrs. min.

9. Birthplace Borden Mines Md
 (Town, county, and state)

10. Usual occupation Machine

11. Industry or business Celanese Corp of Am.

12. Name Robert M. Hill

13. Birthplace Borden Mines Md

14. Maiden name Annie Elizabeth Eister

15. Birthplace Borden Mines Md

16. Informant (wife) Mrs Marshall Hill

Address Frederick Md

17. Burial Date thereof 8/18/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frederick Md

18. Funeral director Jacob Haver

Address 23 E Main St, Frederick Md

19. 8-18 19 48 Mc Nally R. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15/48 19 48 at 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Aug. 15 19 48

Immediate cause of death Congestive pneumonia

Other conditions as above

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Camdenland Md Date signed 8-15/48



RECEIVED

AUG 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07926

61

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? One Day
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 35 Pennsylvania Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Carrie Belle Hough

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Raymond Hough
 7. Birth date of deceased (mo., day, yr.) March 17, 1878
 6. (c) If alive, give age 68 years
 8. AGE: Years 70 Months 5 Days 2 If less than one day
 9. Birthplace Rainsburg, Pa.
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business

12. Name William Morehead Pa.
 13. Birthplace
 14. Maiden name Susan Hoover Pa.
 15. Birthplace

16. Informant Raymond Hough
 Address 35 Pennsylvania Ave
 17. Burial Date thereof August 22, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Hillcrest
 Location Cumberland, Md.

18. Funeral director James F. Scarpelli
 Address Cumberland, Md.

19. Aug 20 19 48 Walter R. Gatz, M.D.
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18, 1948 to Aug. 19, 1948
 and that I last saw him alive on August 18, 1948

Immediate cause of death
Cardiovascular
Renal Disease
Due to
Diabetes Mellitus
 Other conditions

(Include pregnancy within 3 months of death)
 Major findings of operations None Date of op. None
 Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W.F. Williams M.D.
 Address Cumberland Date signed 8-20-48

RECEIVED

AUG 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Outside of
City Limits

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07927

Reg. Dist. No.

24

1. PLACE OF DEATH:

County Allegany
City or town Rocky Ford Camp, Town Creek Md.
(If outside city or town limits, write RURAL and give nearest town)
Rural about 1 year.
How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Allegany
City or town Rocky Ford Camp, Town Creek
(If outside city or town limits, write RURAL and give nearest town)
rural
Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Henry Harrison Keith

3. (b) Social Security Number

705-09-9648

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Virginia B. Haines Keith

6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Dec. 15- 1881

8. AGE: Years 66 Months 7 Days 29 If less than one day hrs. min.

9. Birthplace Washington, Ind.
(Town, county, and state)

10. Usual occupation Ry. Electrician

11. Industry or business Retired

12. Name Joseph Keith

13. Birthplace Ind.

14. Maiden name Mary Carroll

15. Birthplace Ind.

16. Informant Mrs. Donald Long

Address La Vale, Ind.

17. Burial Date thereof Aug. 16, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Memorial Cem

Location Cumberland

19. Funeral director LOUIS STEIN, INC.

Address 117 Fredrick St. Cumberland

19. Aug. 16, 48 W. R. Brantley, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 19 48, at 10.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Aug. 14 19 48

Immediate cause of death Intracranial hemorrhage & exsanguination

Due to

Due to self inflicted revolver wound underneath chin, outlet
*****vertex of skull.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 8-14-48

Where did injury occur? home Town Creek, Allegany Md.
(City or town) (County) (State)

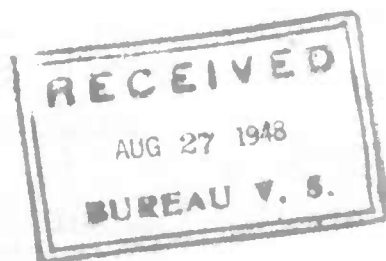
Injured at home, farm, industry, pub'c place (where?) home

Means of injury Automatic pistol Injured at work? no

Deputy Medical Examiner Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 8-14-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07928

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 41 years
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 121 Tilghman St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Anne Phillipa Kenny

3.(b) Social Security Number

214-05-8993

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 9, 1906
 8. AGE: Years 41 Months 9 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Maryland
 (Town, county, and state)
 10. Usual occupation Office Secretary
 11. Industry or business Electric Contracting Co.
 12. Name Thomas P. Kenny
 13. Birthplace Midland, Md.
 14. Maiden name Anna Blake
 15. Birthplace Eckhart, Md.

16. Informant Mrs. Simon Kenny
 Address Hagerstown, Md.
 17. Burial Date thereof August 14, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Peter & Paul's Cemetery
 Location Cumberland, Maryland.
 18. Funeral director John J. Hager
 Address Cumberland, Md.
 19. Aug. 12 19 48 W.R. Bantz M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1948 at 1:35 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1948 to Aug 11, 1948
 and that I last saw h. & R. alive on Aug 10, 1948
 Immediate cause of death Uremia
 DURATION 2 days

Due to Interstitial nephritis
 Due to _____
 Other conditions Anemia & convulsions & hypertension
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE H.V. Deming M.D. M. D. or other _____
Cumberland, Md. Date signed 8-12-48

RECEIVED

AUG 17 1948

BUREAU V. S.

07929

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

175a

CERTIFICATE OF DEATH

Reg. Dist. No. X

Within corporate limits

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3. 1/2 days
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? about 3. 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. Va. County Hampshire
City or town Springfield
(If outside city or town limits, write RURAL and give nearest town)
Street No. rural- near Springfield W. Va.
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME Eston Kesner 3. (b) Social Security Number

4. Sex male 5. Color or race white B. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Elliot P. Kessill Kesner
7. Birth date of deceased (mo., day, yr.) May 5 - 1882 6. (c) If alive, give age 51 years
8. AGE: Years 66 Months 3 Days 18 If less than one day hrs. min.
9. Birthplace Springfield W. Va.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
12. Name George Kesner
13. Birthplace W. Va.
14. Maiden name Rebecca Mozer
15. Birthplace W. Va.

16. Informant Glenn Kesner (son)
Address Springfield W. Va.
17. Burial Date thereof Aug 25 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fessel Ceme
Location Moorefield W. Va.
18. Funeral director Louis Sterio Inc
Address Cumberland Md
19. Aug 24 1948 (Date received by registrar) Registrar W. A. Deming

MEDICAL CERTIFICATION
20. DATE OF DEATH Aug. 23 19 48 at 9.55A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him Dead Aug. 23 19 48
Immediate cause of death Cerebral hemorrhage DURATION 3. 1/2 days
Due to basal fracture of the skull
Due to Belt slipped off of hammernill, he caught belt which threw him against bottom wheel
Other conditions Comminuted fracture of left forearm & humerus, laceration of scalp, ear left side.
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 8-19-48
Where did injury occur? near Springfield, Hampshire, W. Va.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Farm
Means of injury as above Injured at work? yes
Deputy Medical Examiner Allegany Co
23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other
Address Cumberland Md. Date signed 8-23-48

MARGIN RESERVED FOR BINDING

1

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 31 1948

BUREAU V. S.

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County ALLEGANY
 City or town LONACONING
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MR. DAVID LAMB

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED
 6.(b) Name of husband or wife MARIE HUMPHREY
 6.(c) If alive, give age 76 years
 7. Birth date of deceased (mo., day, yr.) APRIL 25, 1868
 8. AGE: Years 80 Months 4 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace MARYLAND
 (Town, county, and state)
 10. Usual occupation NONE
 11. Industry or business _____

12. Name JOHN LAMB
 13. Birthplace SCOTLAND
 14. Maiden name JANE TAYLOR
 15. Birthplace SCOTLAND

18. Informant MEMORIAL HOSPITAL
MEMORIAL AVENUE
 Address _____

17. Burial Date thereof Aug 29, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Allegany Cemetery
 Location Drostburg Md
 18. Funeral director M. E. Latham
 Address Lonaconing Md

19. Aug 27, 1948 Monte D. Smith, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 26, 1948 at 1:50A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1948 to Aug 26 1948
 and that I last saw him alive on Aug 25 1948

Immediate cause of death Chronic suppurative
chronic suppurative
 Due to hyperextension
 Due to arteriosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. E. Elason, M.D.Address 126 Union St. Cumberland Md Date signed 8/26/48

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Hostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:
Maria's Hospital
 How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Allegany
 City or town Eckhart
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Andrew Lancaster

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Lape

7. Birth date of deceased (mo., day, yr.)

May 21 - 1871

6. (c) If alive, give age _____ years

76

8. AGE:

Years

Months

Days

It less than one day

77217

hrs.

min.

9. Birthplace

Eckhart, Alleg. Ind.
(Town, county, and state)

10. Usual occupation

Mayor

11. Industry or business

Govt

FATHER

12. Name

Robert Lancaster

13. Birthplace

York, Penna

MOTHER

14. Maiden name

Mary Cross

15. Birthplace

York, Penna

16. Informant

John Lancaster

Address

Rt. 1, Hostburg, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Eckhart Cemetery

Location

Eckhart, Md.

18. Funeral director

James Hays

Address

Hostburg, Md.

19. 8-20

(Date rec'd by registrar)

19. 48 Mrs. Nancy H. Roe

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 19 48 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/1819 48to 8/1819 48

and that I last saw him alive on

8/18/4819 48

Immediate cause of death

DURATION

① Bronchial asthma

Due to pneumococcus & anthracosis20 yrs ±

② Cardiac failure, (R. sided)

15 min

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank T. Harrah M.D.

M. D. or other

Address 59 E. Main St. Hostburg, Md. Date signed 8/19/48

RECEIVED

AUG 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07932

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Eckhart
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

R. H. #1, Franklin, Ind.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Allegany
 City or town P.O. No. 7, Eckhart
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Eckhart
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Anne Lancaster

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Chas. O. Lancaster7. Birth date of deceased (mo., day, yr.) Aug. 14 - 1872 8. (c) If alive, give age 76 years8. AGE: Years 76 Months 0 Days 7 If less than one day hrs. min.9. Birthplace Eckhart, Allegany, Ind.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Mary Pope13. Birthplace Franklin, Ind.14. Maiden name Unknown

15. Birthplace

16. Informant William LancasterAddress Eckhart, Ind.17. Burial Date thereof Aug. 22 - 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Eckhart CemeteryLocation Eckhart, Ind.18. Funeral director Franklin, Ind.Address Franklin, Ind.19. 8-22 is 48 W. Harry V. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 19 48 at 10.30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/19 19 48 to 8/20 19 48and that I last saw her alive on 8/20 19 48Immediate cause of death Auricular fibrillation DURATION 10 yrs.Arteriosclerotic heart diseaseDue to GriefDue to death of husband 8/18/48.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank T. Harat (MD)Address 59 S. Main St. H. Harat M. D. or otherDate signed 8/21/48

RECEIVED

AUG 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

Outside of
City Limits

07933

1. PLACE OF DEATH:

County AlleganyCity or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. Allegany Grove
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jessie Dickson

7. Birth date of

deceased (mo., day, yr.)

June 14 1902

8. AGE:

Years

Months

Days

If less than one day

4674

hrs.

min.

9. Birthplace

Cresaptown Ind.
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

12. Name Grace Lease

13. Birthplace

Ind.

14. Maiden name

Maie Huff Ind.

15. Birthplace

Wm L Lease

16. Informant

Allegany Grove Ind.

17. Burial

(Burial, cremation, or removal. Which?)

Deeds Cemetery

Cemetery or crematory

Location

Cresaptown Ind.

18. Funeral director

Louis Stein Inc.

Address

Cumberland19. Aug 20

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

720-10-2330

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 18 1948 at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1948 to Aug 18 1948and that I last saw him alive on Aug 12 1948

Immediate cause of death

Acute dilatation of heartDue to Chronic myocarditis 3 yrand Myocarditis 2 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

F. Alan G. Murray M.D.Address Cumberland Ind. Date signed Aug 19 48

RECEIVED

AUG 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

07934

1. PLACE OF DEATH:

County Allegany CountyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

126 W. 3RD. Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 126 W. 3rd St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Lisanti, Mr. Francis, Sr.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Concetta (Trappala) Lisanti6. (c) If alive, give age 65 years

7. Birth date of

deceased (mo., day, yr.)

Oct 15, 1875

8. AGE:

Years

Months

Days

If less than one day

72919

hrs.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual occupation

Bank dealer

11. Industry or business

Unknown

MOTHER

FATHER

12. Name

Francisco Lisanti

13. Birthplace

Italy

14. Maiden name

Antonette Benin

15. Birthplace

Italy

16. Informant

Mrs. Daniel Lisanti

Address

126 W. 3rd St

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 7, 1948

(month) (day) (year)

Cemetery or crematory

St. Marys Cem.

Location

Cumberland

18. Funeral director

James J. Scarpelli

Address

Cumberland

19.

Aug. 5 1948

19

48

W. H. Tautz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 4 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7 1947 to August 4 1948and that I last saw him alive on July 27 1948

Immediate cause of death

hemangio-sarcoma
of liver and lungs

Due to

hemangio

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Primary hemangio
sarcoma of liver Date of op. 6-30-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

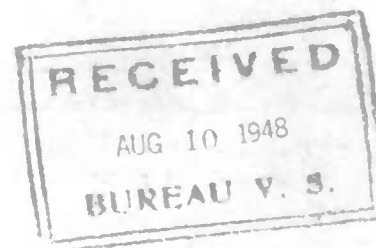
23. SIGNATURE

W. H. Tautz, M.D.

M. D. or other

Address

59 S. E. 8th St.Date signed 8-4-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

07935

174

1. PLACE OF DEATH:

County AlleganyCity or town near Lonaconing Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Waynesburg mine #5How long in hospital or institution? in mine 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Rural) Dan's Mountain
(If outside city or town limits, write RURAL and give nearest town)Street No. near Frostburg Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Loar

3. (b) Social Security Number

216-05-2904

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Gladys*Rose****Loar6. (c) If alive, give age 34 years7. Birth date of deceased (mo., day, yr.) Feb. 21- 19108. AGE: Years Months Days It less than one day
38 5 23hrs.min.9. Birthplace W. Va. near Pinto Md.
(Town, county, and state)10. Usual occupation mine foreman11. Industry or business Georges Creek Coal Co.12. Name William Loar13. Birthplace Lonaconing Md.14. Maiden name Desdemona Powell15. Birthplace Gilmore Md.16. Informant Lim RossAddress Ocean, Maryland17. Burial Date thereof Aug 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Lonaconing Md.18. Funeral director M. EichhornAddress Lonaconing, Md.19. Aug 17 19 48 Jeanette M. Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 19 48 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him in Dead Aug. 14 19 48Immediate cause of death Asphyxiation and
1st, 2nd & 3rd degree burns all at
over body & shock once

Due to.....

Coal mine explosion from coal
dust due to methane gas
Other conditions ignited from an open
type mine motor [9/1/48 note]
(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

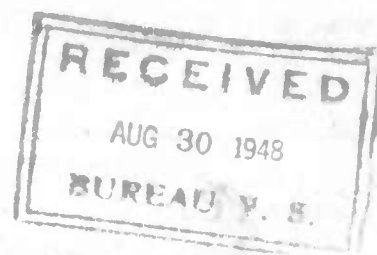
Accident, suicide, or homicide accident Date of 8-14-48Where did injury occur? Lonaconing Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) in coal mineMeans of injury coal dust explosion injured at work? yesDeputy Medical Examiner - Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. OtherAddress Cumberland Md. Date signed 8-15-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*** DO NOT ***

Evidence for change of age shown on this corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

07936

CERTIFICATE OF DEATH

Reg. Dist. No. 4

FILM No. G 117 AUG 30 1948

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? SIX HOURS
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? SIX HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County BEDFORD
City or town HYNDMAN
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

ELLEN BARBARA LOGSDON

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED
6. (b) Name of husband or wife MOSES LOGSDON
7. Birth date of deceased (mo., day, yr.) SEPTEMBER 19, 1868
6. (c) If alive, give age _____ years
8. AGE: Years 79 ~~80~~ Months 11 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace PENNSYLVANIA
(Town, county, and state)
10. Usual occupation HOME MAKER
11. Industry or business _____
12. Name VALENTINE EMERICK
13. Birthplace PENNSYLVANIA
14. Maiden name Mary Burket
15. Birthplace Pennsylvania

16. Informant Mrs. Ruth Sarver
Address Hyndman, Pa.
17. Burial Date thereof 8/23/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Comps
Location Hyndman, Pa.
18. Funeral director Harvey H. Zeigler
Address Hyndman, Pa.

19. Aug 21 19 48 Wm. R. Zeigler, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 20, 1948 at 7:15 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____, and that I last saw him/her Dead Aug. 20 19 48

Immediate cause of death Cerebral hemorrhage DURATION 7 hours

Due to Fell out of bed & hit head on floor.

Due to _____
Other conditions Paraplegia, 3 yrs. duration
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 8-20-48

Where did injury occur? Hyndman Bedford Pa.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Fell out of bed. Injured at work? no
deputy Medical Examiner

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other _____
Address Cumberland Md. Date signed 8-20-48

RECEIVED

AUG 24 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Barton rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 55 years
 Hospital, institution, or street address where death occurred:
1 mile east of Barton
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Alleagny
 City or town Barton - rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1 mile east of Barton
 (If rural, give LOCATION)
- - - - -
 2.(a) If veteran, name war - - - - -

3. (a) FULL NAME

WALTER ISAAC McCLOUD

3. (b) Social Security Number

215-20-7289

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Lucy Fink McCloud
 6.(c) If alive, give age 48 years
 7. Birth date of deceased (mo., day, yr.) August 15, 1880
 8. AGE: Years 68 Months 0 Days 2 If less than one day
- - - - - hrs. - - - - - min.

9. Birthplace unknown
 (Town, county, and state)
 10. Usual occupation miner
 11. Industry or business coal mine
 12. Name Hyder McCloud
 13. Birthplace unknown
 14. Maiden name Unknown
 15. Birthplace

16. Informant Mrs. Lucy McCloud
 Address Barton, Maryland
 17. Burial Burial Date thereof August 19, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Laurel Hill Cemetery
Moscow, Maryland
 Location
 18. Funeral director Ellsworth S. Boal
 Address Westernport, Maryland

19. Aug. 19 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 19 48, at 10:10p

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 10 48 to Aug 16 48
 and that I last saw him alive on Aug. 16, 1948

Immediate cause of death Chronic Myocarditis and Myocardial Degeneration Not Specific Is Rheumatic

Due to 2 Years

Other conditions Pulmonary and Generalized Edema
 (Include pregnancy within 3 months of death)

Major findings of operations None

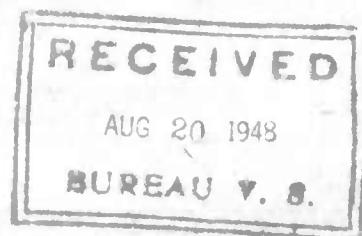
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson, M.D.
Piedmont, W. Va. M. D. or other
 Address Piedmont, W. Va. Date signed 8-18-48



RECEIVED

AUG 20 1948

BUREAU V. S.

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 1 day 7 hours 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 205 Springdale Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Phyllis M. McCreary

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Frank F. McCreary Jr.

7. Birth date of deceased (mo., day, yr.)

October 12, 1923

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

24103

hrs.

min.

9. Birthplace CUMBERLAND, Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Robert Humbird

13. Birthplace

Maryland

14. Maiden name

Helen Barger

15. Birthplace

Maryland16. Informant Memorial Hospital

Address

Cumberland, Maryland17. BURIAL
(Burial, cremation, or removal, Which?)

Date thereof

8/18/1948
(month) (day) (year)

Cemetery or crematory

ROSE HILL CEME.

Location

CUMBERLAND, Md.

18. Funeral director

LOUIS STEIN, INC.

Address

CUMBERLAND, Md.19. Aug 18 19 48
(Date recorded by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 48 at 4:10 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 14 1948 to Aug 15 1948
and that I last saw him alive on 15 19 48

Immediate cause of death

DURATION

Isolated
meperidine
(poison)about
4 hrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W.F. Williams
Cumberland Date signed 8-16-48

RECEIVED

AUG 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

07939

1. PLACE OF DEATH:

County Allegany
City or town Midland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Charles Offner M. Gowan

3.(b) Social Security Number

217-05-3512

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Sara Ellen O'Rourke

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1874 6.(c) If alive, give age 47 years

8. AGE: Years 73 Months 9 Days 12 If less than one day hrs. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Jackson Coal Mine Lonscoring

12. Name Jessie M. Gowan

13. Birthplace Scotland

14. Maiden name Anna Elliott

15. Birthplace Scotland

16. Informant Mrs. Harry Wilson

Address Midland, Md.

17. Burial Date thereof Aug 9, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Michael's Cemetery

Location Frostburg, Md.

18. Funeral director M. Eichham

Address Lonscoring, Md.

19. Aug 8 19 48 Pauline M. Coal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 19 48 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to 8/6 19 48
and that I last saw him alive on 8/5 19 48

Immediate cause of death

Coronary thrombosis
(2) miner's asthma

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Dye M.D.
M.D. or other

Address Lonscoring, Md. Date signed 8/7/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
AUG 13 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since birth

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 2 1/2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 E. Elder St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Rosemarie McGreevy

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7- 19428. AGE: Years Months Days If less than one day
5 10 19 hrs. min.9. Birthplace Cumberland Md.
(town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Owen J. McGreevy13. Birthplace Midland Md.14. Maiden name Dorothy Spencer15. Birthplace Staunton Va.16. Informant Owen J. McGreevyAddress 7 E. Elder St Cumberland Md.17. Burial Date thereof August 30, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Sts. Peter & Paul CemeteryLocation Cumberland, Maryland18. Funeral director John J. HaferAddress Cumberland, Maryland19. Aug 29 1948 Hunter R. Brantley, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 19 48 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h er Dead Aug. 26 19 48Immediate cause of death Abdominal hemorrhage DURATION 3 hrs.Due to ruptured spleen & LiverDue to hit by an automobileOther conditions abrasions of body & laceration of scalp.
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-26-48Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State) St.Injured at home, farm, industry, public place (where?) Va. Ave. near ElderMeans of injury hit by an Auto. Injured at work? no
Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. M. D. or otherAddress Cumberland Md. Date signed 8-26-48

RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany
 City or town Westernport, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

John F. McGuigan McGuigan

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Stella Gannon Mc Guigan

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1870
 6. (c) If alive, give age _____ years

8. AGE: Years 78 Months 6 Days 18 It less than one day _____ hrs. _____ min.

9. Birthplace Barton, Allegany ? Md.
 (Town, county, and state)

10. Usual occupation C & P R R11. Industry or business Retired Conductor12. Name John Mc Guigan13. Birthplace Md.14. Maiden name Ellen Naughton15. Birthplace Md.16. Informant Mrs Stella McGuiganAddress Westernport, Md.17. Burial Date thereof Sept. 1, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peters CemeteryLocation Westernport, Md.18. Funeral director W. Harold F. Fulkerson Jr.Address Piedmont, W. Va19. Sept. 1, 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1948 19____ at 10:30pm

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him im dead Aug. 30, 1948 19____Immediate cause of death Chronic MyocarditisDURATION severalyears

Due to _____

Due to _____

Other conditions Edema of Limbs.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Deputy Medical Examiner Allegany Co23. SIGNATURE H. V. Denning M.D. M. D. or otherAddress Cumberland Md Date signed 8-30-48

RECEIVED

SEP 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

07942

465

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Month
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Allegany
City or town... Gettysburg
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Andrew McKenzie

3. (b) Social Security Number

None

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Grand Mary Croft

7. Birth date of deceased (mo., day, yr.) Aug 26, 1879

8. AGE: Years 68 Months 11 Days 11

9. Birthplace Wiltan, Garrett Co., Md.

10. Usual occupation Farmer-Retired

11. Industry or business Own Farm

12. Name Elias McKenzie

13. Birthplace Wiltan, Garrett Co., Md.

14. Maiden name Elizabeth

15. Birthplace Wiltan, Garrett Co., Md.

16. Informant Mrs. Lewis Green

Address Westport

17. Burial Date thereof Aug 10, 1948

(Burial, cremation, or removal, which?)

Cemetery or crematory St. Anne's Cemetery

Location Wiltan, Garrett Co., Md.

18. Funeral director J. E. Eickhorst

Address Gettysburg, Md.

19. Date rec'd by registrar Aug 8, 1948

Registrar J. R. Roub...

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1948 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to August 7, 1948

and that I last saw him alive on August 6, 1948

Immediate cause of death Coronary Thrombosis with mitral

Due to 3 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Johnson M.D.

Address Cumberland, Md. Date signed 8-1-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CERTIFICATE OF DEATH

A STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH

DECLARATION OF DEATH

RECEIVED

AUG 17 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07943

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County alleganyCity or town Blower Hill Farm
(If outside city or town limits, write RURAL and give nearest town)Street No. Baltimore Pike Rt 2 Cumberland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Emery Britt Mc Luckie

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

May 11, 1900

8. AGE:

Years

Months

Days

If less than one day

4838

hrs.

min.

9. Birthplace

Frostburg, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Agry Farming

12. Name

Andrew J. Mc Luckie

13. Birthplace

Frostburg, Md.

14. Maiden name

Alice Sabine

15. Birthplace

Frostburg, Md.

16. Informant

Mrs. Rena J. Signory

Address

Rt 4 Cumberland Md.

17. Burial

(Burial, cremation, or removal, which?)

Funeral Home

Cemetery or crematory

Cumberland, Md.

Location

John J. Haley

18. Funeral director

Cumberland Md.

Address

Aug 22 1948

(Date rec'd by registrar)

Walter D. Smith, Md.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 19 48 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-17-48 to 8-19-48and that I last saw him alive on 8-19-48

Immediate cause of death

DURATION

Cerebral Vascular DiseaseDue to Chronic HypertensiveDue to Heart Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None Date of op None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.F. Williams

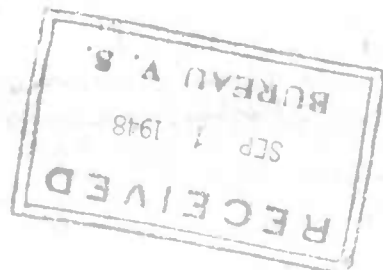
M. D. or other

Address Cumberland Date signed 8-20-48

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AUG 24 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 1/4 yrs. (10 mo. 19 ds.)
 Hospital, institution, or street address where death occurred:
Allegany Street
 How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Allegany
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1

3. (a) FULL NAME

Louise Bohing Muir

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband as wife Adam Muir
 6.(c) If alive, give age 78 years
 7. Birth date of deceased (mo., day, yr.) September 27, 1866
 8. AGE: Years 81 Months 10 Days 19 If less than one day ✓ hrs. ✓ min.

9. Birthplace Lonaconing, Allegany, Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER 12. Name Conrad Bohing

13. Birthplace Germany

MOTHER 14. Maiden name Christine Pratt

15. Birthplace Germany

16. Informant Mrs. Thomas Dick

Address Lonaconing Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Aug. 19, 1948
 (month) (day) (year)

Cemetery or crematory Oak Hill

Location Lonaconing Maryland

18. Funeral director M. Eichhorn

Address Lonaconing Maryland

19. Aug 19 19 48 Janette M. Boal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 19 48, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 78, to Aug 19 78, and that I last saw her alive on Aug 19 78

Immediate cause of death metastatic Carcinoma of
Abdomen

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operative

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Dye, M.D.
 M.D. or other

Address Lonaconing Md. Date signed 8/19/48

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SEP 2 1948

BUREAU V. S.

DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

126

07946

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... ALLEGANY
 City or town..... CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 15 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL Hospital
 How long in hospital or institution?..... 15 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... W. VA. County..... Mineral
 City or town..... KEYSER
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 112 WEST PIEDMONT ST.
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ☒

3. (a) FULL NAME

MRS. REBECCA S. NEVILLE

3. (b) Social Security Number

None

4. Sex..... F 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... MARRIED

6. (b) Name of husband or wife..... WILLIAM W. NEVILLE

7. Birth date of deceased (mo., day, yr.)..... 8/23/1904 6. (c) If alive, give age..... 47 years

8. AGE: Years..... 44 Months..... 0 Days..... 2 If less than one day..... hrs. min.

9. Birthplace..... ILLINOIS
(Town, county, and state)10. Usual occupation..... HWFE

11. Industry or business.....

FATHER 12. Name..... SEATON, CHARLES
 13. Birthplace..... ILLINOIS

MOTHER 14. Maiden name..... WAYMAN, ELIZABETH
 15. Birthplace..... W. VA.

16. Informant..... Memorial Hospital
 Address..... Cumberland, Md

17. Burial..... Date thereof..... Aug 28, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Romney Cem
 Location..... Romney, W. Va.

18. Funeral director..... Mayh Cantor
 Address..... Romney, W. Va.

19. Aug 25 19 48 Walter R. Davis, Md
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 25 - 1948 at 3:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 10 - 1948, to Aug 25 - 1948

and that I last saw him alive on Aug 27 - 1948
 Immediate cause of death..... Pulmonary embolism

Due to..... Cholelithiasis
 Due to..... Cholelithiasis
 Other conditions..... Cholelithiasis

Due to..... Cholelithiasis
 Due to..... Cholelithiasis
 Other conditions..... Cholelithiasis

Due to..... Cholelithiasis
 Due to..... Cholelithiasis
 Other conditions..... Cholelithiasis

(Include pregnancy within 3 months of death)
 Major findings of operations..... gall bladder
 Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.
gall bladder

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

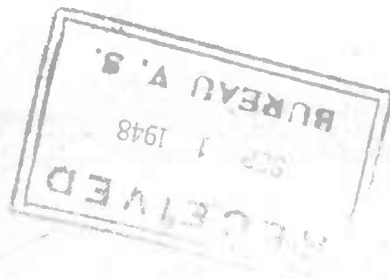
23. SIGNATURE..... F. M. Wilson
 Address..... Cumberland, Md Date signed..... 8-25-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07947

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred

517 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 Greene St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Johnson Newnam

3. (b) Social Security Number

705-07-9670

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Margaret A. Loebl

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Jan 15 1880

8. AGE:

Years

Months

Days

If less than one day

68

7

16

hrs.

min.

9. Birthplace

Piedmont St Va

(Town, county, and state)

10. Usual occupation

Bolt - Forge

11. Industry or business

Railway

12. Name

Charles R. Newnam

13. Birthplace

Unknown

14. Maiden name

Virginia Ogle

15. Birthplace

Ind.

16. Informant Mrs Margaret L. Newnam

Address Cumberland

17. Burial

Date thereof Sept 2 48

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St Peter & Paul Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Sept 1 48

(Date rec'd by registrar)

W. L. Tantz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 31 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-31-48 to Aug 31 1948

and that I last saw him alive on Aug 31 1948

Immediate cause of death

Coronary Thrombosis

DURATION 2 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op. None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm. F. Weir

Address Cumberland

Date signed 8/31/48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

07948

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County AlleganyCity or town Rural - Little Orleans
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rural - Little Orleans
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Henry E. Norris

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married8. (b) Name of husband or wife Grace Robey Norris7. Birth date of deceased (mo., day, yr.) May 13, 1869 6. (c) If alive, give age 68 years8. AGE: Years 79 Months 2 Days 28 If less than one day _____ hrs. _____ min.9. Birthplace Piney Plains, Allegany Co., Md.
(Town, county, and state)10. Usual occupation B & O Conductor - Retired

11. Industry or business

12. Name Joseph Norris13. Birthplace Allegany Co., Md.14. Maiden name Martha Jane Mann15. Birthplace Allegany Co., Md.16. Informant Mrs. Grace R. NorrisAddress Little Orleans, Md.17. Burial Date thereof Aug 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Yonke's GraveyardLocation Piney Plains18. Funeral director Charles R. BastAddress Hancock, Md.19. Aug 13 19 48 Miss J. Watson
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10, 1948 at 12:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8, 1948 to Aug 10, 1948 and that I last saw him alive on Aug 10, 1948

Immediate cause of death

Chronic MyocarditisDue to Chronic Nephritis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Shaffer M.D.Address Hancock, Md. M. D. or other _____Date signed 8/10/48

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AUG 23 1948

BUREAU V. S.

DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

07949

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:

MEMORIALHow long in hospital or institution? 11 DAYS

3. (a) FULL NAME

WILLIAM HENRY NORRIS.

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife Mary Lowery

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

JAN. 14, 1887

8. AGE:

Years

Months

Days

If less than one day

61626

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

Construction Supt.

11. Industry or business

Building trades

FATHER

12. Name

JOHN FENTON NORRIS.

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

VIRGINIA MARGARET RUCKER

15. Birthplace

VIRGINIA

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Aug 13, 1948
(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hoffer

Address

Cumberland, Md.

19.

Aug. 12 1948
(Date rec'd by registrar)W. B. Trout, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

allegany

City or town

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No.

466 GOETHE STREET,

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

214-05-8514

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 10 1948 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 31 1948, to August 10 1948
and that I last saw him alive on August 9 1948

Immediate cause of death

Peritonitis - diffuse

DURATION

Aug 9 - 10

Due to

Leakage - esophago -One day

Due to

peritonitis
Partial resection stomach7 days

Other conditions

Adenocarcinoma stomach,
obstruction and metastasis to
(Include pregnancy within 3 months of death)

Major findings of operations

Spleen and pancreas
same as above

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

no

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. B. Trout, M.D.

M. D. or other

Address

Cumberland, Md.Date signed Aug 12, 1948

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

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AUG 14 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07950

DR MIRKIN

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... **ALLEGANY**
 City or town... **CUMBERLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... **18 DAYS**
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?... **18 DAYS**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... **W. VIRGINIA** County... **MINERAL**
 City or town... **KEYSER**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... **71 NOZELL ST**
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME

VANCE H PARISH

3. (b) Social Security Number

217-10-7866

4. Sex... **MALE** 5. Color or race... **WHITE** 6. (a) Single, married, widowed, or divorced... **MARRIED**
 6. (b) Name of husband or wife... **DOROTHY DUBBS**
 7. Birth date of deceased (mo., day, yr.)... **NOV 20, 1905**
 8. AGE: Years... **42** Months... **8** Days... **16** If less than one day... hrs. min.

9. Birthplace... **W. VA**
 (Town, county, and state)
 10. Usual occupation... **CELANESE**
 11. Industry or business... **DEPT 39**
 12. Name... **PARISH, CHARLES**
 13. Birthplace... **Unknown**
 14. Maiden name... **ELLA DAVIS**
 15. Birthplace... **W. VA**

16. Informant... **MEMORIAL HOSPITAL**
 Address... **MEMORIAL AVE**
 17. Removal... **Aug. 6, 1948**
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
 Cemetery or crematory... **Keyser Cem**
 Location... **Keyser, W. Va.**
 18. Funeral director... **Rogers Funeral Home**
 Address... **Keyser, W. Va.**
 19. **Aug. 6, 1948** **W. H. Tooty, M.D.**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... **AUGUST 6** 19 **48** at **11:05** ^a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July, 19 19 **48** to **AUGUST 6** 19 **48**
 and that I last saw h.i.m. alive on **AUGUST 5** 19 **48**

Immediate cause of death... **METASTATIC MALIGNANCY** DURATION **6 Mos.**
CHEST

Due to... **CARCINOMA, PRIMARY SITE**
UNDETERMINED

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations... **BIOPSY - ADENOCARCINOMA**
 Date of op.....

Autopsy results... **None**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... **Frank C. Bailey M.D.**

Address... **Memorial Hosp. Cumberland** Date signed... **Aug 6/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 10 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

07951

93d

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 wks.Hospital, institution, or street address where death occurred: Memorial Hosp.How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County alleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 100 Laing Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles T Peer.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife Unknown7. Birth date of deceased (mo., day, yr.) Unknown abt 1877 6. (c) If alive, give age _____ years8. AGE: Years 71 Months ? Days ? If less than one day _____ hrs. _____ min.9. Birthplace Romney W. Va.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Hampton Peer.13. Birthplace W. Va.14. Maiden name Unknown15. Birthplace IL16. Informant Mr. McKeaAddress Augusta W. Va.17. Burial Date thereof Aug 9 '48
(Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory Bethel CoveLocation near Romney W. Va.18. Funeral director Lucas & Son IncAddress Cumberland md19. Aug. 9 19 48 W. J. Tapp, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 48 at 8:24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 6 19 48 to August 9 19 48and that I last saw him alive on August 7 19 48

Immediate cause of death

Hemiplegia

Due to

Hypertensive C.V. Disease

Due to

Other conditions

DURATION

4 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE B. M. Schuriller, M.D.Address 41 Everett St.Date signed August 9, 1948

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AUG 17 1948
BUREAU N. S.

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AUG 17 1948
BUREAU N. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07952

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred: Business Hosp. Frostburg
 How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Ind. County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 55 McCulloch St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Elbert P. Bluff

3. (b) Social Security Number

215-10-4463

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Louise R. Bluff

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Nov. 19-1872

8. AGE:

Years

Months

Days

If less than one day

75816

hrs.

min.

9. Birthplace:

Frostburg, Ind.
(Town, county, and state)

10. Usual occupation

Retired Cigarette Worker

11. Industry or business

FATHER

12. Name

Conrad Bluff

13. Birthplace

Frostburg, Ind.

MOTHER

14. Maiden name

Emma Bluff

15. Birthplace

Frostburg, Ind.

16. Informant

146 N. 2nd St. Frostburg

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Everest Cemetery

Location

Everest, Ind.

18. Funeral director

Jacob J. J. J.

Address

Frostburg, Ind.

19.

(Date rec'd by registrar)

8-5-48Miss Nancy V. Rye

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 5, 1948 at 9:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28, 1948 to Aug 5, 1948

and that I last saw him/her alive on

August 5, 1948

Immediate cause of death

Cerebral hemorrhage
C-V-R disease

DURATION

9 days
5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. Lattery M.D.

M. D. or other

Address

Frostburg, Ind.Date signed 8/6/48

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07953

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Alleg
 City or town Oldtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Miss Elmire Piper

3. (b) Social Security Number

4 Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) aug 9.18 14 6.(c) If alive, give age _____ years
 8. AGE: Years 64 Months _____ Day 18 If less than one day _____ hr. _____ min.

9. Birthplace Oldtown, Maryland
 (Town, county, and state)
House Work

10. Usual occupation

11. Industry or business

FATHER 12. Name Ezekial Piper
 13. Birthplace Maryland
 MOTHER 14. Maiden name Martha. Wagent
 15. Birthplace nebr aska

16. Informant Memorial Hospital
 Address Cumberland Md

17. Burial Date thereof Aug 28, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hardsocks.
Near Oldtown, Md
 Location Wolford.s Funeral Home

18. Funeral director _____
 Address 125 S Liberty St
Cumberland Md

19. Aug 27 19 48 Walter R. [unclear]
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 19 48 at 8:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 19 48, to Aug 26 19 48
 and that I last saw him alive on Aug. 26 19 48

Immediate cause of death Left cerebral hemorrhage
Right Hemiplegia
 Due to Stroke
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE ccy. S. [unclear]
Cumberland M.D. or other
 Address _____ Date signed Aug 27, 1948

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yearsHospital, institution, or street address where death occurred:
Memorial HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. 2, Williams Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edgar Van Meter Pratt

3. (b) Social Security Number

705-05-4560

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Elinor E. Messick7. Birth date of deceased (mo., day, yr.) March 10, 18866. (c) If alive, give age 61 years

8. AGE:

Years

Months

Days

If less than one day

62429

hrs.

min.

9. Birthplace Moorefield, W. Va.
(Town, county, and state)10. Usual occupation Retired B.O. Shopman11. Industry or business Railroad12. Name Jacob Pratt13. Birthplace W. Va.14. Maiden name Susan Sherman15. Birthplace W. Va.16. Informant Mrs. May BishopAddress Narrows, Va.17. Burial
(Burial, cremation, or removal. Which?) Date thereof August 12, 1948
(month) (day) (year)Cemetery or crematory St. Herman CemeteryLocation Cumberland, Md.18. Funeral director John J. H. H.Address Cumberland, Md.19. Aug. 11, 1948
(Date rec'd by registrar) Registrar W. R. Taub

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1948 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Aug 9, 1948and that I last saw him live on Aug 9, 1948

Immediate cause of death

Chronic myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. R. TaubAddress Cumberland, Md. Date signed 8/11/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07954

RECEIVED

AUG 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

07955

93d

1. PLACE OF DEATH:

County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 59 yrs 11 mo 19 das
 Hospital, institution, or street address where death occurred:
State Street
 How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. State Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1

3. (a) FULL NAME

William Preston

3. (b) Social Security Number

220-10-2368

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Irene Ryan Preston

7. Birth date of deceased (mo., day, yr.) August 21, 1888

8. AGE: Years 59 Months 11 Days 19 If less than one day 60 years

9. Birthplace Lonaconing, Allegany, Maryland
 (Town, County, and state)

10. Usual occupation Miner (Retired)

11. Industry or business Lonaconing Coal Co.

12. Name William Preston

13. Birthplace Barton, Maryland

14. Maiden name White

15. Birthplace Unknown

18. Informant Mrs. Irene Preston

Address Lonaconing, Md.

11. Burial Burial Date thereof Aug 14 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

18. Funeral director M. E. Eighon

Address Lonaconing, Md.

19. Aug 14 19 48 Janette M. Boal
 (Date of death by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 48 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Coronary thrombosis

Due to Arteriosclerosis Vascul

Due to Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Paul Eugene Dry, M.D.
 Address Lonaconing, Md. Date signed 8/13/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 30 1948

BUREAU Y. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1948

07956

DR B. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....20 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?.....20 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....54 MARION ST.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MRS BERTHA PRINCE

3. (b) Social Security Number

None

4. Sex.....FEMALE 5. Color or race.....WHITE 6.(a) Single, married, widowed, or divorced.....WIDOW

6.(b) Name of husband or wife.....CHARLES PRINCE

7. Birth date of deceased (mo., day, yr.).....NOV 7, 1872 6.(c) If alive, give age..... years

8. AGE: Years.....75 Months.....9 Days.....4 It less than one day..... hrs. min.

9. Birthplace.....MARYLAND, Cumberland, Alleg. Co.
 (Town, county, and state)

10. Usual occupation.....HOUSEWIFE11. Industry or business.....Own Home12. Name.....HESTER CRHISTY James13. Birthplace.....MARYLAND, Cumberland14. Maiden name.....REBECCA JACKSON, Sarah15. Birthplace.....MARYLAND, Cumberland16. Informant.....MEMORIAL HOSPITALAddress.....MEMORIAL AVE

17. Burial Date thereof.....Aug 14, 1948
 (Burial, cremation, or removal, where?) (month, day, year)

Cemetery or crematory.....Stillcrest CemeteryLocation.....Cumberland, Md.18. Funeral director.....John J. HefnerAddress.....Cumberland, Md.

19. Aug 12, 1948 Registrar.....W.R. Toub M.D.
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....AUG 11 1948 at 9:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15, 1947 to 8/11/48 1948
 and that I last saw him/her alive on 8/11/48 1948

Immediate cause of death.....Respiratory failure
underlying cause Chronic nephritis
 Due to.....(9/20/48-49)

Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE.....W.R. Toub M.D.
 M. D. or other.....
 Address.....Cumberland, Md. Date signed.....9/2/48

RECEIVED

AUG. 17 1948

BUREAU V. S.

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07957

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegheny
 City or town Homestead
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7.8 years, 1 day
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Homestead
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Douglas Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret Barclay Kelton

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Vernon Kelton
 7. Birth date of deceased (mo., day, yr.) Aug. 25, 1870
 6.(c) If alive, give age _____ years
 8. AGE: Years 78 Months - Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Homestead, Allegheny Co., Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Robert Barclay13. Birthplace Scotland14. Maiden name Mary Frazier15. Birthplace Nov Scotia16. Informant Mrs. Mary R. EvansAddress 135 E. Froebel Blvd. Altadena California17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug. 29, 1948
(month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Homestead, Maryland18. Funeral director W. EickhoenAddress Homestead, Md.19. Aug. 30 19 48 Janette M. Boal
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 19 48 at 3 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/1 19 48 to 8/26 19 48 and that I last saw him alive on 8/26 19 48Immediate cause of death Cerebral ischemia

DURATION

Due to Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Eugene Dye, M.D.
M. D. or other _____Address Homestead, Md. Date signed 8/28/48

RECEIVED

SEP 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 week
 Hospital, institution, or street address where death occurred:
7 mt. Pleasant St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Michigan County... Wayne
 City or town... Detroit 13
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7632 Midbury
 (If rural, give LOCATION)
 2. (a) If veteran, name war...

3. (a) FULL NAME

Robert Gracie Rankin

3. (b) Social Security Number

382-05-0251

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Annie Rankin

7. Birth date of deceased (mo., day, yr.)

May 30, 1888

6. (c) If alive, give age

54 years

8. AGE:

Years 60 Months 2 Days 12 It less than one day
 hrs. min.

9. Birthplace

Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation

inspector

11. Industry or business

Rockford Motor Car Co.

MOTHER FATHER

12. Name

Alex Rankin

13. Birthplace

Maryland

14. Maiden name

Katherine McCready

15. Birthplace

Scotland

16. Informant

Mrs. John Geis

Address

Frostburg, Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Aug. 15, 1948
(Month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

J. R. Hurst

Address

Frostburg, Md.

19.

8-14
(Date rec'd by registrar)

19.

48
(Date signed by registrar)W. H. H. Rose
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... August 12 1948, at 9 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
8-12 1948, to 8-12 1948
 and that I last saw him alive on 8-12 1948

Immediate cause of death

respiratory failure

DURATION

2

Due to

pulmonary tuberc. (2)

Due to

possibly tuberculosis

Other conditions

possibly tuberculosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Sol Wolf Wolperman M.D.
 M. D. or other

Address... Frostburg Date signed... 8-14-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route 4, Box 286
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Velvet Love Reckley

3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) August 17, 1948
 8. AGE: Years 0 Months 0 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)10. Usual occupation Infant

11. Industry or business _____

12. Name Hartley M. Reckley13. Birthplace Cumberland, Md.14. Maiden name Shirley A. Schaidt15. Birthplace Oldtown, Md.16. Informant Hartley M. ReckleyAddress Rt. 4, Cumberland, Md.17. Burial Date thereof August 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Gabriel CemeteryLocation N. Cumberland, Md.18. Funeral director John J. HoffaAddress Cumberland, Md.19. August 19, 1948 W.R. Krantz, Md.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948 at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
17 Aug 1948, to 19 Aug 1948
 and that I last saw her alive on 19 Aug 1948

Immediate cause of death ATELECTASIS
 DURATION 2 days

Due to Prematurity

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. Stoen, M.D.
M. D. or other _____Address 1015 Centre St. Date signed 20 Aug 48

RECEIVED

AUG 24 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 MINUTES
 Hospital, institution, or street address where death occurred:
MEMORIAL Hospital
 How long in hospital or institution? 40 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
 City or town Near CUMBERLAND, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. BOX 415 ROUTE #1
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

LURELLA SUSAN REED

3. (b) Social Security Number
None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife ELLSWORTH REED
 6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1872
 8. AGE: Years 75 Months 10 Days 17 If less than one dayhrs.min.

9. Birthplace W. VA. Philippi
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Robinson, LOUIS WILSON

13. Birthplace W. VA. HANNAH

14. Maiden name HATHAWAY, HANNAH

15. Birthplace W. VA.

16. Informant Troy T. Marks

Address Rt. #1 Cumberland, Md.

17. Burial Date thereof Aug. 26, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Marys' Chapel Cem.

Location Near Grafton, W. Va.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. Aug 26 19 48 Hunter R. Trantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 19 48 at 800 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/30 19 48 to 8/23 19 48
 and that I last saw him alive on Aug 23 19 48

Immediate cause of death Rupture of lung abscess of right lung into pleural space
 Due to Lung abscess
Tubercular pneumonia
 Due to.....

DURATION

24 hours
1 month
2 months

Other conditions Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Avella Or Weisman MD M. D. or other

Address 122 Bedford St., Cumberland Date signed 8/24/48

RECEIVED
SEP 1 1948
BUREAU V. B.

Dr. McLean.
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany
County.....
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
502 Rose Hill Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 502 Rose Hill Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
GENEVIEVE D. REINHART

3. (b) Social Security Number
212-03-6272

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife None
7. Birth date of deceased (mo., day, yr.) July 13, 1875 6. (c) If alive, give age years
8. AGE: Years 73 Months 0 Days 19 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business C. & P. Telephone Employee

12. Name John Reinhart
13. Birthplace Maryland
14. Maiden name Lucinda Downey
15. Birthplace Maryland

16. Informant Michael D. Reinhart
Address 502 Rose Hill Ave., Cumberland,

17. Burial Date thereof Aug. 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
S. S. Peter & Paul
Cemetery or crematory
Location Cum berland, Md.

18. Funeral director H. Wayne George
Address Cumberland, Md.

19. Aug. 3 19 48 W.R. Tautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2, 19 48 at 4:30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sub 19 48 to July 21, 1948
and that I last saw her alive on July 21st, 1948

Immediate cause of death Hypertrophic Cirrhosis DURATION 6 mos.
Chronic Myocarditis 7

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James E. McLean M.D. M. D. or other

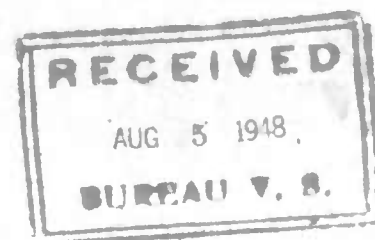
Address 49 Green St. Date signed 8-3-48.

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

AUG 5 1948.

BUREAU V. S.

Dr. W.F.WILLIAMS MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07962

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 40 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
 City or town CUMBERLAND
 (if outside city or town limits, write RURAL and give nearest town)
 Street No. 218 DAVIDSON STREET
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. LUCY RHIND

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED
 6.(b) Name of husband or wife JOHN RHIND
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) OCTOBER 10, 1885
 8. AGE: Years 63 Months 10 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace MARYLAND
 (Town, county, and state)
 10. Usual occupation HOUSE WIFE
 11. Industry or business _____
 12. Name WILLIAM HARRISON
 13. Birthplace PENNSYLVANIA
 14. Maiden name ELIZABETH HEBNER
 15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
 Address MEMORIAL AVENUE
 17. Burial Date thereof 8/15/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Cumberland, Md.
 18. Funeral director William H. Kight
 Address Cumberland, Md.

19. Aug 15 19 48 Wm H Kight
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 13, 1948 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-20-46 to 8-13-48
 and that I last saw him alive on 8-12-48

Immediate cause of death

DURATION

Myocardial infarction
 Due to arteriosclerosis

See to Chronic Salomon
Heart Disease
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operation

Perforated ulcer
 Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

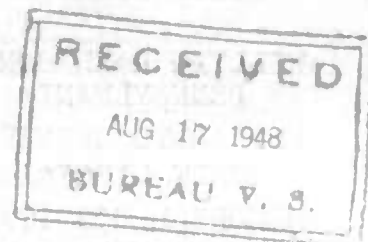
23. SIGNATURE

W.F. Williams
 M. D.
 Address Cumberland Date signed 8-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

07963

160e

1. PLACE OF DEATH:

County Allegany
 City or town McCoole, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

93 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town McCoole
(If outside city or town limits, write RURAL and give nearest town)Street No. 93 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Infant Riggleman

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1948

8. AGE: Years Months Days If less than one day
3 hrs. min.

9. Birthplace McCoole, Md.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Walter Riggleman13. Birthplace Keyser, W.Va.14. Maiden name Dorthey Foltz15. Birthplace Keyser, W.Va.16. Informant Walter RigglemanAddress McCoole, Md.17. Burial Date thereof 8-7-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory QueenspointLocation Keyser, W.Va.18. Funeral director N. Howard RogersAddress 85 S. Main St. Keyser, W.Va.19. Aug. 25 1948 Registrar

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7, 1948 19 48 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug. 7, 1948 19 48 to 19 48

and that I last saw him alive on Aug. 7 19 48

Immediate cause of death Prematurity

Due to Breech presentation
ruptured membranes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Norman Reever, M.D.Address Westernport Md. Date signed 8/15/48

RECEIVED

AUG 26 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07964

8

1. PLACE OF DEATH:

County Allegany
City or town Midland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 68 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Midland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Drucilla Foote Robertson

3. (b) Social Security Number

2

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Joseph G. Robertson

7. Birth date of deceased (mo., day, yr.)

Oct 19, 1860

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

87104

hrs.

min.

9. Birthplace

Lonaconing, Allegany Co., Md
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Own home

FATHER

12. Name

George Foote

13. Birthplace

England

14. Maiden name

Elizabeth Buckle

15. Birthplace

England

16. Informant

Dr. Richard Elliott

Address

Midland Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Aug 23 1948
(month) (day) (year)

Cemetery or crematory

Old Carry Cemetery

Location

Lonaconing, Md

18. Funeral director

Wm. C. Bishorn

Address

Lonaconing, Md

19. Aug 26

19 48

Jannette M. Boral

Registrar

Date signed by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 19 48 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/26 19 48 to 8/23 19 48

and that I last saw her alive on

8/23 19 48

Immediate cause of death

Uremia, underlying cause

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul Eugene Dry, MD

(M.D. or other)

Address

Lonaconing, MdDate signed 8/25/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1948

BUREAU V. S.

Side of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07965

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
R.D. #2, Cumberland, Md. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 yrs.
 Hospital, institution, or street address where death occurred:
R.D. #2 Baltimore Pike, Cumberland, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
 City or town R.D. #2 Cumberland, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Baltimore Pike
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

James Martin Ryan

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Mary A. McGuire
 7. Birth date of deceased (mo., day, yr.) Nov. 1, 1889 6. (c) If alive, give age _____ years
 8. AGE: Years 78 Months 9 Days 11 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1948 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 47 to August 48 and that I last saw him alive on July 28, 1948

Immediate cause of death Semility with psychosis DURATION 3 yrs.
 Due to Cerebral arteriosclerosis 3 yrs

Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

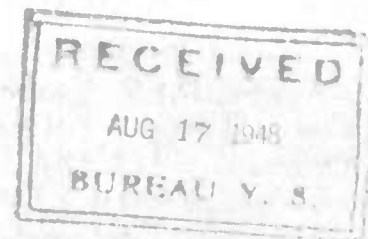
23. SIGNATURE R. W. Lewis King Jr. M.D. M.D. or other _____
Cumberland Address _____ Date signed Aug 11/48

9. Birthplace West Virginia (Town, county, and state)
 10. Usual occupation Machinist
 11. Industry or business B.O. Railroad
 12. Name John Ryan
 13. Birthplace Ireland
 14. Maiden name Delia Noon
 15. Birthplace Ireland
 16. Informant Mrs. O.N. Magruder
 Address R.D. #2 Cumberland, Md.
 17. Burial Date thereof Aug. 14 1948 (month) (day) (year)
 Cemetery or crematory Mt. Calvary Cemetery
 Location Grafton, W. Va.
 18. Funeral director Louis Stein, Inc.
 Address Cumberland, Md.
 19. Aug 12 1948 (Date rec'd by registrar) Walter R. Smith, M.D. Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 4

07366

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 years
 Hospital, institution, or street address where death occurred:
Narrows Park
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 215 Narrows Park
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Isabel Screen

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife..... 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1887

8. AGE: Years 60 Months 11 Days 13 If less than one day..... hrs. min.

9. Birthplace Longsoring, Allegheny Co., Md.
 (Town, county, and state)

10. Usual occupation School Teaching

11. Industry or business Johnson Heights School

12. Name Joseph Screen

13. Birthplace England

14. Maiden name Isabel Robertson

15. Birthplace Longsoring Md.

16. Informant Mrs. Ernest Screen

Address 215 Narrows Park, Cumberland Md.

17. Burial Date thereof Aug. 28, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Willescent Burial Park

Location Cumberland Md.

18. Funeral director M. Eichhorn

Address Longsoring Md.

19. Aug 27 19 48 Winters County Md.
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 25 19 48 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to Aug 25 19 48

and that I last saw him alive on Aug 18 19 48

Immediate cause of death Pulmonary Embolism

Due to Deveroid Sarcomatosis DURATION 1 1/2 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE V. H. Mason

Address 1362 W. 11th Cumberland Md. M. D. or other

Date signed 8/27/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

Outside of City Limits

RECEIVED

AUG 31 1948

BUREAU V. S.

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122 6

07967

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL, CUMBERLAND, MD.How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County PRESTONCity or town TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

BETTY LOU SHAFFER

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITESINGLE

6. (b) Name of husband or wife _____

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 9/14/478. AGE: Years Months Days If less than one day
11 MOS _____ hrs. _____ min.9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name HARRY R. SHAFFER13. Birthplace W. VA.14. Maiden name THELMA I. JOHNSON15. Birthplace W. VA.16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.17. Removal Date thereof Aug 24, 48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Terra AltaLocation Terra Alta, W. Va.18. Funeral director C. F. CallumAddress Terra Alta, W. Va.19. Aug 24, 19 48 Hunter & Son, Md.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 24 48 at 10:10A21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Aug. 23 19 48 to Aug 24 19 48
and that I last saw him alive on Aug. 24 19 48Immediate cause of death Infarct of MyocardiumDue to Focal Impaction

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Infarct of Myocardium

Date of op. _____

Autopsy results Infarct of Myocardium

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. W. ElasonAddress 126 Furrow Cumberland Md Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07968

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Weeks
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 4 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 515 Fayette St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs Theodora S. Shaffer

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Elsie A Shaffer
 7. Birth date of deceased (mo., day, yr.) April 29 1887
 8. AGE: Years 61 Months 3 Days 6 It less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Allegheny Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Edward A Clark
 13. Birthplace Maryland
 14. Maiden name Emma Rossworm
 15. Birthplace Maryland

16. Informant Elsie A Shaffer
 Address 515 Fayette St

17. Burial Date thereof Aug 7 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory S.S. Peter & Paul
 Location Fayette St. Cumberland Md.

18. Funeral director H. Wayne George
 Address Cumberland Md.

19. Aug. 6, 19 48 W.R. Hantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4, 19 48 at 3:22P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 4, 19 48 to Aug 4, 19 48
 and that I last saw her alive on 8-4-48

Immediate cause of death Carcinoma Rectum DURATION 3 mo.

Due to _____

Due to _____

Other conditions Pneumonia 3 weeks

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of Rectum
Polypoid mass Date of op. 7-26-48

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W.R. Hantz M. D. or other _____

Address Cumberland Date signed 8-5-48

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in correct age column. Write cause of death clearly and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

601 Piedmont Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 601 Piedmont Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MRS. KATHERINE SHANHOLT

3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FemaleWhiteWidowed6.(b) Name of husband or wife Asa H. Shanholt

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 18668. AGE: Years Months Days If less than one day
81 1 7 hrs. min.9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Leonart Shertzner13. Birthplace Germany14. Maiden name Barbara Hopach15. Birthplace Germany16. Informant Walter C. ShanholtAddress 601 Piedmont Ave. Cumberland, Md.17. Burial Date thereof Aug. 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Maryland18. Funeral director William H. KightAddress Cumberland, Maryland19. Aug. 7, 1948 W.R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1948 at 11-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945, to Aug 5, 1948
and that I last saw him alive on Aug 5, 1948

Immediate cause of death

Cerebral hemorrhage 6 hrsDue to hypertension and
Heart disease yearsDue to chronic nephritis several
years

Other conditions

Spitzer
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

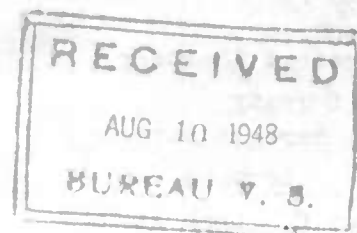
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Allen G. Murray, M.D.
M. D. or otherAddress Cumberland, Md. Date signed Aug 7, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age ~~XXXXXXXXXX~~ shown on:
 FILM No. G 117 SEP 23 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07970

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
Cumberland
 City or town 10 hrs.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 hrs.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Penna. County Bedford
 City or town Hyndman
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 10
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Harry Ellsworth Smeak

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Lily Purbaugh
 6. (c) If alive, give age 19 years
 7. Birth date of deceased (mo., day, yr.) 10/11/1887
 8. AGE: Years 60 Months 11 Days 23 If less than one day hrs. min.

9. Birthplace Hyndman, Pa.
 (Town, county, and state)
 10. Usual occupation B & O R.R. Co. Employee
 11. Industry or business

12. Name Jacob Smeak
 13. Birthplace Pa.
 14. Maiden name Lily Purbaugh
 15. Birthplace Pa.

16. Informant Russell Smeak
 Address Hyndman, Pa.

17. Burial 8/7/1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hyndman, Pa. Cemetery
 Location Hyndman Pa.

18. Funeral director Harvey H. Zeigler
 Address Hyndman, Pa.

19. Aug 6 19 48 W. H. Kautz, M.D.
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 19 48 at 9:15 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 48 to Aug 4 19 48
 and that I last saw him alive on Aug 4 19 48
 Immediate cause of death Acute Congestive Heart Failure
 DURATION 1 day
 Due to Acute Cholecystitis
 Other conditions 1 wk
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. None
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of None
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE John A. Lopper M.D.
 Address Hyndman Pa. Date signed 8.4.48
 M. D. or other

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County AlleganyCity or town near Ionaconing Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Waynesburg Mine #5How long in hospital or institution? In mine 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Zihlman
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. 2 Frostburg Md.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Bernard Smith

3. (b) Social Security Number

214-01-0090

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malewhitemarried6. (b) Name of husband or wife Ethel Louise Williams Smith6. (c) If alive, give age 44 years

7. Birth date of

deceased (mo., day, yr.)

Nov. 4-1901

8. AGE:

Years

Months

Days

If less than one day

46910

hrs.

min.

9. Birthplace

Hungary

(Town, county, and state)

10. Usual occupation

mine foreman

11. Industry or business

Georges Creek Coal Co.

FATHER

12. Name

Bernard Kovatch (Smith)

MOTHER

13. Birthplace

Hungary

14. Maiden name

Mary Balint

15. Birthplace

Hungary

16. Informant

Mrs. Mary Howsare,

Address

Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 17, 1948
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery,

Location

Frostburg, Md.

18. Funeral director

J. R. Durst,

Address

Frostburg Md.19. 8-17

(Data rec'd by registrar)

19 48

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Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 19 48 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Aug. 14 19 48

Immediate cause of death

1st, 2nd & 3rd burns of face at head & hands. 1st burns of back once. also shock.Coal mine explosion from coal dust due to methane gas ignited

Other conditions

from an open type mine motor [9/1/48 also]

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-14-48Where did injury occur? near Ionaconing Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) in coal mineMeans of injury Coal dust explosion yesDeputy Medical Examiner Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.Address Cumberland Md Date signed 8-15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07972

Reg. Dist. No.

1. PLACE OF DEATH:

County allegany
 City or town Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
9 Ormond St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 600 Central Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Eva Smith

7. Birth date of deceased (mo., day, yr.) July 12-1876 6.(c) If alive, give age 74 years

8. AGE: Years 72 Months 0 Days 30 If less than one day hrs. min.

9. Birthplace Smithsburg-alleg-md
 (Town, county, and state)

10. Usual occupation retired

11. Industry or business Hagerwood Contracting Co.

12. Name John Smith

13. Birthplace U.S.A

14. Maiden name Ann F. Conady

15. Birthplace Smithsburg md.

16. Informant Charles Smith

Address Route 1 - Cumberland, md.

17. Burial Date thereof Aug 14-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory allegany

Location Smithsburg

18. Funeral director J. R. Dwyer

Address Smithsburg

19. 8-14 1948 Mr. Nancy H. Roe
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

214-07-0191 ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1948, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1947, to Aug 11 1948

and that I last saw him alive on Aug 11 1948

Immediate cause of death Chs Myocarditis DURATION 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

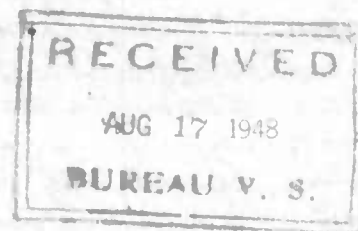
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm Lane M.D. or other

Address Frostburg md Date signed 8-13-48



DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

181

07973

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 143 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 143 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PENNSYLVANIA County FULTON
 City or town AMARANTH
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MR. RUSSELL STECKMAN

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED
 6. (b) Name of husband or wife STELLA CLINGERMAN
 6. (c) If alive, give age 53 years
 7. Birth date of deceased (mo., day, yr.) SEPTEMBER 14, 1888
 8. AGE: Years 59 Months 11 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace PENNSYLVANIA, Bedford Co.
 (Town, county, and state)
 10. Usual occupation FARMER
 11. Industry or business _____

12. Name FRANK STECKMAN
 13. Birthplace PENNSYLVANIA
 14. Maiden name MARY PENNELL
 15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
MEMORIAL AVENUE
 Address _____

17. Burial Burial Date thereof Aug. 27, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Fairview Cem.
 Location Near Artemas, Penna.
 18. Funeral director H. Wayne George
 Address Cumberland, Md.

19. Aug 27 19 48 Walter R. Trout, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 25, 1948 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4, 1948 to Aug 25, 1948
 and that I last saw him alive on August 24, 1948

Immediate cause of death Septicemia secondary
severe 2nd degree
burns both legs, gluteal
region, abdomen and
hands
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of April 4, 1948
 Where did injury occur Little Orleans, Allegany (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury burning grass Injured at work? no
 23. SIGNATURE W. H. Maw Jr. M.D. M. D. or other Aug 25, 1948
 Address Cumberland, Md. Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 31 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

07974

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

605 Lincoln Street

How long in hospital or institution? About 10 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 Lincoln Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Mary Steiner

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Burd Steiner

7. Birth date of deceased (mo., day, yr.) April 4, 1874

8. AGE: Year 74 Months 4 Days 3 If less than one day

hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Snyder

13. Birthplace Pennsylvania

14. Maiden name Sarah Haines

15. Birthplace Pennsylvania

16. Informant Mrs. Schumacker

Address 605 Lincoln Street, City.

17. Burial Date there Aug. 10, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Charles Baker Cem

Location Pottsville, Penna

18. Funeral director Charles J. Lord

Address Pottsville, Penna.

19. Aug. 8 19 48 W. F. Fautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 19 48 at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 44, to Aug 7 19 48

and that I last saw him alive on Aug 6 19 48

Immediate cause of death

Myocardial Infarction

Due to Arteriosclerosis

Due to Chronic Hepatitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

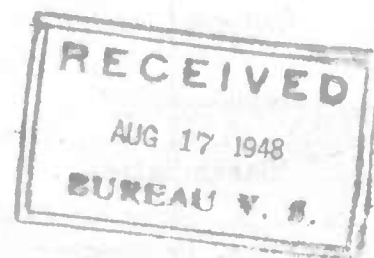
23. SIGNATURE F. Alan G. Munro, M.D.

Address Cumberland, Md. Date signed Aug 7/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 312 S Allegheny St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sylvia Stewart

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Jas. Wallace Stewart

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept 22 18998. AGE: Years 48 Months 10 Days 25 If less than one day _____ hrs. _____ min.9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Allen Bradford

13. Birthplace

14. Maiden name Marta Parker

15. Birthplace

16. Informant J. W. StewartAddress Cumberland17. Burial Date thereof Aug 18 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Midway Cem.Location Midway Pa.18. Funeral director Home Stein & Co.Address Cumberland Ind.19. Aug 18 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-17 19 48 at 7:37 P.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 5 19 48 to Aug 17 19 48and that I last saw her alive on Aug 17 19 48Immediate cause of death Pulmonary embolism DURATIONDue to Diabetes mellitus

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. P. Cleckley M. D. or otherAddress 496 Meade St Date signed 8/18/48

RECEIVED

AUG 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... AlleghenyCity or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Allegheny Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Va. County...City or town... Winchester
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Benjamin Arthur Strawderman

3. (b) Social Security Number

223-14-2396

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

Mary Johnston

7. Birth date of

deceased (mo., day, yr.)

Jan 9 1902

8. AGE:

Years

Months

Days

If less than one day

4674

hrs.

min.

9. Birthplace

Mathias, Hardy Co., W. Va.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

General Farming

12. Name

Joshua Strawderman

13. Birthplace

Mathias, W. Va.

14. Maiden name

Virginia Foltz

15. Birthplace

Mathias, W. Va.

16. Informant

Calvin Strawderman

Address

222 Fulton St - Cumberland Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Aug 16 1948
(month) (day) (year)

Cemetery or crematorium

Pleasant Grove Meth. Cem.

Location

Near Cumberland Md.

18. Funeral director

John J. Hafer

Address

Cumberland

19. Aug 16 19 48

(Date registered by registrar)

Walter A. [unclear]
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 19 48 at 8:11/48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/11/48

19

to 8/13

19

48and that I last saw him alive on 8/13/48 19

Immediate cause of death

Carcinoma of
intestines tract

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of
intestines

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

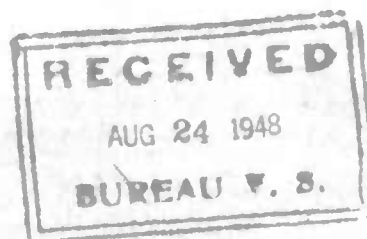
John H. [unclear]
M. D. or other

Address

Cumberland Md Date signed 8/16/48

*Mr. Rogers
and
Rees*

*Call
65*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07977

Reg. Dist. No. 8

1. PLACE OF DEATH:

County AlleganyCity or town Midland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 yrsHospital, institution, or street address where death occurred:
-How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Midland
(If outside city or town limits, write RURAL and give nearest town)Street No. L
(If rural, give LOCATION)2.(a) If veteran, name war L

3. (a) FULL NAME

Thomas H. Tighe

3. (b) Social Security Number

L4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Margaret E. Strueman6.(c) If alive, give age 22 years7. Birth date of deceased (mo., day, yr.) Dec. 20, 18658. AGE: Years 82 Months 8 Days 9 If less than one day - hrs. - min.9. Birthplace Ireland
(Town, county, and state)10. Usual occupation Coal Mines11. Industry or business Consolidation Coal Co.12. Name John Tighe13. Birthplace Ireland14. Maiden name Magdalene Heller15. Birthplace Garrett Co. Md16. Informant Mrs Walter RossAddress Midland, Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept 1, 1948
(month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Frostburg, Md18. Funeral director M. EichhornAddress Lanacoring, Md19. Sept 1, 1948 Jannette M. Neal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

DST

20. DATE OF DEATH 29 Aug 19 48, at 10 A.M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Aug 19 48, to 29 Aug 19 48and that I last saw him alive on 29 Aug 19 48Immediate cause of death Cerebral Hemorrhage & Paralysis

DURATION

Due to arteriosclerosisDue to hypertensionOther conditions -

(Include pregnancy within 8 months of death)

Major findings of operations -Date of op. -Autopsy results None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE John B. Davis, M.D.Address Frostburg, Md M. D. -Date signed 8/30/48

RECEIVED

SEP 3 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town ROUTE #4 CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. R. F. D. #4
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

MISS LOIS JEAN TIPTON

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Nov. 20, 1928

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

19812

hrs.

min.

9. Birthplace

WISCONSIN, Shawano

(Town, county, and state)

10. Usual occupation

NONE

11. Industry or business

12. Name

EARL TIPTON

13. Birthplace

WEST VIRGINIA

14. Maiden name

WIEGAND, GRACE

15. Birthplace

WISCONSIN

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVE., CITY

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug. 6, 1948

(month) (day) (year)

Cemetery or crematory

Davis Memorial Cem.

Location

Oldtown Rd. Cumberland, Md.

18. Funeral director

H. Wayne George

Address

Cumberland, Md.

19.

Aug. 5, 1948
(Date rec'd by registrar)1948W. F. D. #4M. D.Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 2, 1948 at 11:07 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 31, 1948 to Aug 2, 1948and that I last saw him alive on Aug 2, 1948Immediate cause of death Myocardial Infarctiondue to Atherosclerotic Cornea

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address W. F. D. #4 Date signed 8/5/48

RECEIVED
JUN 10 1948

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

111C

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany
 City or town Mt. Savage
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

DANIEL FRANKLIN
Baby Boy Trimble

3.(b) Social Security Number _____

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) August 10, 1948
 6. (c) If alive, give age _____ years
 8. AGE: Years 0 Months 0 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Allegany, Md.
 (Town, county, and state)

10. Usual occupation Infant

11. Industry or business _____

12. Name Jesse Trimble

13. Birthplace Mt. Savage, Md.

14. Maiden name Suzanna Winebrenner

15. Birthplace Mt. Savage, Md.

16. Informant Jesse Trimble

Address Mt. Savage, Md.

17. Burial Date thereof Aug 17, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. George Episcopal Cemetery

Location Mt. Savage, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. Aug 17, 1948 Walter A. Smith, Md.
 (Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948 at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST - 10, 1948 to AUGUST - 14, 1948
 and that I last saw him alive on AUGUST 14, 1948

Immediate cause of death TETANY DURATION 4 DAYS

Due to CALCIUM DEFICIENCY

Due to _____

Other conditions PULMONARY EDEMA

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William E. Mosley M. D. other _____

Address Mt. Savage Md. Date signed 8-16-48

RECEIVED

AUG 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07980

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

906 Gay St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 906 Gay St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

WALTER JAMES VALENTINE

3.(b) Social Security Number

214-05-5843

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
8.(b) Name of husband or wife <u>Sarah Twigg</u>		
7. Birth date of deceased (mo., day, yr.) <u>Nov. 5, 1890</u>		
8. AGE: Years <u>57</u>	Months <u>9</u>	Days <u>6</u>
If less than one dayhrs.min.		

9. Birthplace <u>Cumberland, Md.</u> (Town, county, and state)
10. Usual occupation <u>Truck driver</u>
11. Industry or business <u>Bennett Transfer</u>
12. Name <u>William Valentine</u>
13. Birthplace <u>Md.</u>
14. Maiden name <u>?</u>
15. Birthplace <u>?</u>

16. Informant <u>Mrs. Sarah Valentine</u>
Address <u>906 Gay St., Cumberland, Md.</u>
17. <u>Burial</u> Date thereof <u>Aug. 14, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory <u>Centenary Church Cem.</u>
Location <u>Bedford Rd. near Cumberland</u>
18. Funeral director <u>H. Wayne George</u>
Address <u>Cumberland, Md.</u>

19. <u>Aug. 14</u> 19 <u>48</u> <u>Walter R. Zantz, M.D.</u> (Date read by registrar) Registrar
--

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1948, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 1948, to Aug. 11, 1948
 and that I last saw him alive on August 1, 1948

Immediate cause of death coronary heart failure DURATION 6 months

Due to chronic myocarditis DURATION 6 months

Due to retrograde heart dilation DURATION 1 year

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE W. R. Zantz M. D. or other

Address 58 Greene St. Date signed 8-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

By Bing

RECEIVED
AUG 17 1948
BUREAU V. S.

RECEIVED
AUG 17 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County... Ailegany
 City or town... Westernport.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 1 hour.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... West Va. County... Mineral
 City or town... Piedmont.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 90 West Hampshire.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

James F. Walsh.

3. (b) Social Security Number

232-01-1361

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1889.8. AGE: Years Months Days If less than one day
58 11 6 hrs. min.9. Birthplace Piedmont, West Va.
(Town, county, and state)10. Usual occupation Bookkeeper- Clerk.11. Industry or business Campbell Coal Co.12. Name Bryan Walsh.13. Birthplace Ireland.14. Maiden name Mary Ellen Bouhen.15. Birthplace Bloomington, Maryland.16. Informant Joseph Walsh.Address Rowlesburg, West Va.17. Burial Date thereof August 10, 1948.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peters Cemetery.Location Westernport, Maryland.18. Funeral director Wm Howard Fulbright Jr.Address Piedmont, West Va.19. August 12, 1948 Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1948 at 9am M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1948 to Aug 7th 1948and that I last saw him alive on Aug 7th 1948Immediate cause of death Coronary Occlusion, DURATION

Due to

Due to

Other conditions Dilation of heart.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. Walsh M. D. or otherAddress Piedmont, W. Va. Date signed 8/8/48

RECEIVED BY THE BUREAU OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

RECEIVED BY THE BUREAU OF THE ARMY

ARMY LEECH

PAG CONTENT

RECEIVED BY THE BUREAU OF THE ARMY

RECEIVED

AUG 9 1948

BUREAU V S

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07982

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY COUNTY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? _____
Hospital, institution, or street address where death occurred:
MEMORIAL, CUMBERLAND, MD.
How long in hospital or institution? 17 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County HAMPSHIRE
City or town ROMNEY
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) ☒
2.(a) If veteran, name war _____

3. (a) FULL NAME CHARLES E. WEBSTER
3. (b) Social Security Number None

4. Sex MALE
5. Color or race COLORED
6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife BESSIE WASHINGTON WEBSTER

7. Birth date of deceased (mo., day, yr.) 10/4 - 1870
6. (c) If alive, give age 75 years

8. AGE: Years 77 Months 9 Days 29
If less than one day _____ hrs. _____ min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business _____

12. Name JOHN WEBSTER
13. Birthplace W.VA.

14. Maiden name HARRIET HARDY

15. Birthplace WEST VIRGINIA

16. Informant Memorial Hospital
Address Cumberland, Md

17. Burial Date thereof August 6, 1948
(Burial, cremation, or removal. Which?) _____ (month) (day) (year)
Cemetery or crematory Allegheny County Cemetery

Location Cumberland, Md.

18. Funeral director John J. Nofre
Address Cumberland, Md.

19. Aug. 6 19 48 W.L. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 3, 1948 19 _____ at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from _____ 19 _____ to _____ 19 _____
and that I last saw him Dead Aug. 3 19 48

Immediate cause of death Chronic myococarditis
DURATION several years

Due to _____

Due to _____

Other conditions arteriosclerosis, also edema of arms & legs
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? Deputy Medical Examiner - Allegheny Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other _____
Address Cumberland Md. Date signed 8-4-48

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07983

92d

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 54-6-14
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 14 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1 N. Waverly Terrace
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3.(a) FULL NAME

Charles A. Wiegman

3.(b) Social Security Number

214-05-8936

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mildred Dickson
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb 11 1894

8. AGE: Years 54 Months 6 Days 14 It less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Ind.
 (Town, county, and state)

10. Usual occupation Mechanic
 11. Industry or business Steel Co.

12. Name Henry B. Wiegman
 13. Birthplace Cumberland Ind.

14. Maiden name Helene Snowery
 15. Birthplace Penna

16. Informant Mrs Mildred D. Wiegman
 Address Cumberland

17. Burial Burial Date thereof Aug 27 48
 (Burial, cremation, or removal, which) (month) (day) (year)
 Cemetery or crematory S. Peter + Park Cem

Location Cumberland Ind

18. Funeral director Louis Stein Inc
 Address Cumberland

19. Aug 26 19 48 Walter P. Dwyer, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 19 48 at 12:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Dec. 46 to 25 Aug 48
 and that I last saw him alive on 24 Aug 48

Immediate cause of death Valvular heart disease, mitral, rheumatic Since 1943

Due to Subacute Bacterial Endocarditis 2 mos.

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
See above.

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter P. Dwyer, M.D.
 M. D. or other _____

Address 110 S. Centre St. Cumb. Date signed 26 Aug/1948

RECEIVED

AUG 31 1948

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 DAY
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State WEST VIRGINIA County GRANT
 City or town MAYSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MR. ASA WEIMER

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWER

6.(b) Name of husband or wife MARY ELIZABETH KEPLINGER

7. Birth date of deceased (mo., day, yr.) JUNE 8, 1876
 8. (c) If alive, give age _____ years

8. AGE: Years 72 Months 2 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace West VIRGINIA
 (Town, county, and state)
RETIRED

10. Usual occupation _____

11. Industry or business _____

12. Name WEIMER, ISREAL13. Birthplace WEST VIRGINIA14. Maiden name MARGARET F. BURGESS15. Birthplace PENNSYLVANIA16. Informant MEMORIAL HOSPITALAddress MEMORIAL AVE.17. Burial Date thereof 8 12 48
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Strachy CemeteryLocation near Petersburg, W. Va.18. Funeral director P.E. Thrush & SonAddress moorfield W. Va.19. August 10 19 48 W.F. Williams, M.D.
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 10, 19 48 at 1:45 A.M.I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9, 19 48 to August 10, 19 48and that I last saw him alive on August 10, 19 48Immediate cause of death Shock fromintestinalobstruction(mechanical)

Due to _____

Due to _____

Other conditions _____

Major findings of operations Cripplingat bedside Date of op. 8-9-48Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W.F. WilliamsAddress Cumberland Date signed 8-10-48

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AUG 17 1948

BUREAU V. S.

Dr. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07930

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Outside of
City Limits

1. DEATH: Allegany
 County R. D. #2 Williams Rd. Cumb. Md.
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Williams Rd. Cumberland, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Rural near Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Williams Rd. near Cumb.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

DAVID WALKER WENTLING

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Nina May Long
 6.(c) If alive, give age 74 years
 7. Birth date of deceased (mo., day, yr.) Jan. 1, 1873
 8. AGE: Years 75 Months 7 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Near Cumberland, Md.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business Farmer
 12. Name John Wentling
 13. Birthplace Penna.
 14. Maiden name Emily McElfish
 15. Birthplace Maryland

16. Informant Mrs. Nina Wentling
 Address R. D. #2 Cumberland, Md.
 17. Burial Aug. 28, 1948
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Mt. Pleasant Cem
 Location Near Cumberland, Md.
 18. Funeral director H. Wayne George
 Address Cumberland, Md.

19. Aug 28 19 48 Walter R. Long, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 19 48 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 1948 to August 25 1948
 and that I last saw him alive on August 24 1948

Immediate cause of death Cerebral Lung DURATION (3.)

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

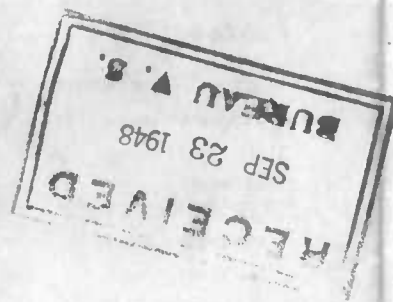
23. SIGNATURE B. M. Rhendler, M.D. M. D. or other _____
 Address 41 Green St. Date signed Sept 13, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



24 hours

With the certificate (in) Dr. Fred Williams

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

07984

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

519 Conrad Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 519 Conrad Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

James H. White

3.(b) Social Security Number

578-03-71374. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mamie Thomas7. Birth date of deceased (mo., day, yr.) June 15, 18878. AGE: Years 61 Months 1 Days 18 If alive, give age 66 years
hrs. min.9. Birthplace Cumberland Allegheny Co. Md.
(Town, county, and state)10. Usual occupation Paper Hanger11. Industry or business Self Employed.12. Name James H. White13. Birthplace Cumberland Md.14. Maiden name Caroline Elbin15. Birthplace Artemus, Pa.16. Informant Mrs. James H. WhiteAddress 519 Conrad Ave, Cumberland, Md.17. Burial Date thereof Aug 6, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director John J. HaferAddress Cumberland Md.19. Aug 6 19 48 Lois Brantley, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1948 at 10:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1948 to July 19, 1948and that I last saw him alive on July 19, 1948Immediate cause of death Carcinoma of stomach
Rectum with metastases
to liver, ovariesDue to Small pulmonaryDue to and was actually

filled with it.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Colostomy was doneabove was present none

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins
M. D. or other

Address Date signed

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AUG 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07986

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumbersland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

514 Frederick Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumbersland
(If outside city or town limits, write RURAL and give nearest town)Street No. 514 Frederick St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Catherine Wickertshrein

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F W Widow6. (b) Name of husband or wife Andrew Wickertshrein

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 19508. AGE: Years Months Days If less than one day
98 2 28 44 min.9. Birthplace Selbyburg, Indiana
(Town, county, and state)10. Usual occupation Housework11. Industry or business Home12. Name George Sliker13. Birthplace Cumbersland, Indiana14. Maiden name Rosinae Kerber15. Birthplace Cumbersland, Indiana18. Informant George WickertshreinAddress Cumbersland Ind17. Burial Date thereof Aug 7, '48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Eugen Grove Cem.Location Wilminghton, Ohio18. Funeral director LOUIS STEIN, INCAddress Cumbersland Ind19. Aug 5 1948 W.D. Jones M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 1948 to Aug 1948and that I last saw him alive on Aug 3 1948Immediate cause of death Definitive hemorrhageDue to Tumor of colon (typeundetermined)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or otherAddress 110 S. Centre St. Date signed 8-5-48

RECEIVED

AUG 10 1948

BUREAU V. S.

With a corporate limit

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Matthews

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

07987

Reg. Dist. No. 4

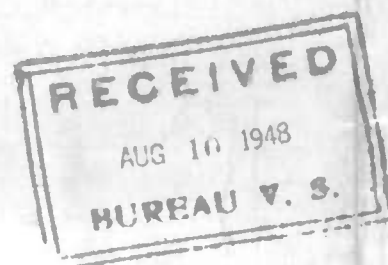
1. PLACE OF DEATH: County <u>Allegany</u> City or town <u>Cumberland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Allegany Hospital</u> How long in hospital or institution? <u>5 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Allegany</u> City or town <u>Cumberland</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>527 Henderson Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war	
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3. (a) FULL NAME <u>James Wilson</u>	3. (b) Social Security Number <u>214-05-4845</u>
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4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>									
6. (b) Name of husband or wife <u>Leatha Arnold</u>											
7. Birth date of deceased (mo., day, yr.) <u>Sept. 14, 1883</u>		6. (c) If alive, give age <u>61</u> years									
8. AGE: <table border="1"><tr><td>Years</td><td>Months</td><td>Days</td><td>It less than one day</td></tr><tr><td><u>64</u></td><td><u>10</u></td><td><u>21</u></td><td>.....hrs.min.</td></tr></table>	Years	Months	Days	It less than one day	<u>64</u>	<u>10</u>	<u>21</u>hrs.min.			
Years	Months	Days	It less than one day								
<u>64</u>	<u>10</u>	<u>21</u>hrs.min.								
9. Birthplace <u>Barton Allegany Maryland</u> (Town, county, and state)											
10. Usual occupation <u>Brewery worker</u>											
11. Industry or business <u>Cumberland Brewery</u>											
MOTHER	12. Name <u>Thomas Wilson</u>										
	13. Birthplace <u>Scotland</u>										
	14. Maiden name <u>Elizabeth ?</u>										
15. Birthplace <u>Scotland</u>											

16. Informant <u>Mrs. Leatha Wilson</u> Address <u>527 Henderson Ave., Cumberland</u>	
17. Burial (Burial, cremation, or removal. Which?) <u>Rose Hill Cem.</u> Cemetery or crematory <u>Cumberland, Md.</u> Location	Date thereof <u>Aug. 8, 1948</u> (month) (day) (year)
18. Funeral director <u>H. Wayne George</u> Address <u>Cumberland, Md.</u>	
19. <u>Aug. 7</u> 19 <u>48</u> (Date rec'd by registrar)	

MEDICAL CERTIFICATION	
20. DATE OF DEATH <u>Aug. 5</u> 19 <u>48</u> at <u>8:00A</u> M	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Dec. 4</u> 19 <u>47</u> to <u>Aug. 5</u> 19 <u>48</u> and that I last saw him alive on <u>Aug. 5</u> 19 <u>48</u>	
Immediate cause of death <u>Chronic Hepatitis</u>	DURATION
Due to <u>Chronic Bronchitis</u>	
Due to <u>Chronic Hepatitis</u>	
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings of operations	
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of	
Where did injury occur? (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?)	
Means of injury Injured at work?	
23. SIGNATURE <u>C. M. Matthews</u> M. D. or other	
Address <u>49 Greene St</u> Date signed <u>8/6/48</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07988

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County LANCASTERCity or town BAINBRIDGE
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

NORMAN WITT

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

SINGLE,

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 1873

6.(c) If alive, give age _____ years

8. AGE: Years 75 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace PENNSYLVANIA
(Town, county, and state)10. Usual occupation FARMING, WORKED FOR OTHER11. Industry or business FARMERS12. Name WITT, YOHN13. Birthplace PENNSYLVANIA14. Maiden name SHOWORK, SUSAN15. Birthplace Hyndman, Pa.16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.17. Burial Date thereof Aug. 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Palo Alto CemeteryLocation Hyndman, Pa.18. Funeral director H. H. ZEIGLER,Address HYNDMAN, PA.19. Aug 30 1948 Witt, Norman
(Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 27 1948 at 2:25 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21 1948 to Aug 27 1948
and that I last saw him alive on Aug 27 1948Immediate cause of death Diabetes Mellitus DURATION 4 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John A. Topper MD M. D. or otherAddress Hyndman, Pa. Date signed 8/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948
25-
1873

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

07989

13/a

1. PLACE OF DEATH:

County.....ALLEGANY
City or town.....CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....MD County.....ALLEGANY
City or town.....CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.....527 GREEN ST CITY
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

WILLIAM C. YEAGER
4. Sex.....MALE 5. Color or race.....WHITE 6.(a) Single, married, widowed, or divorced.....MARRIED

6.(b) Name of husband or wife.....MARY CHRIST
6.(c) If alive, give age.....43 years

7. Birth date of deceased (mo., day, yr.).....APRIL 20, 1900

8. AGE: Years.....48 Months.....3 Days.....10 hrs..... min.

9. Birthplace.....CUMBERLAND, Alleg. Co., Md.
(Town, county, and state)

10. Usual occupation.....CARPENTER

11. Industry or business.....Self

12. Name.....YEAGER, WILLIAM

13. Birthplace.....PRUSSIA

14. Maiden name.....MERTIE GROSS

15. Birthplace.....CUMBERLAND, Maryland

16. Informant.....MEMORIAL HOSPITAL

Address.....MEMORIAL AVE CITY

17. Burial.....Burial Date thereof.....Aug. 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Pleasant Grove

Location.....Rt. #40 near Cumberland, Md.

18. Funeral director.....H. Wayne George

Address.....Cumberland, Md.

19. Date rec'd by registrar.....Aug. 12, 1948 Registrar.....W. R. Faatz, M.D.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....AUG 10 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 8 1948 to August 10 1948
and that I last saw him alive on August 10 1948
Immediate cause of death.....Uremia

Due to.....Cardiovascular - renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....George M. Simon M. D. or other

Address.....Memorial Hospital Date signed.....Aug. 12, 1948

RECEIVED

AUG 14 1948

BUREAU V. S.